Book 05

PUBLIC HEALTH RESOURCE NETWORK

Behavior Change Communication and Training for Health

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
(2005-2012)

Book 5

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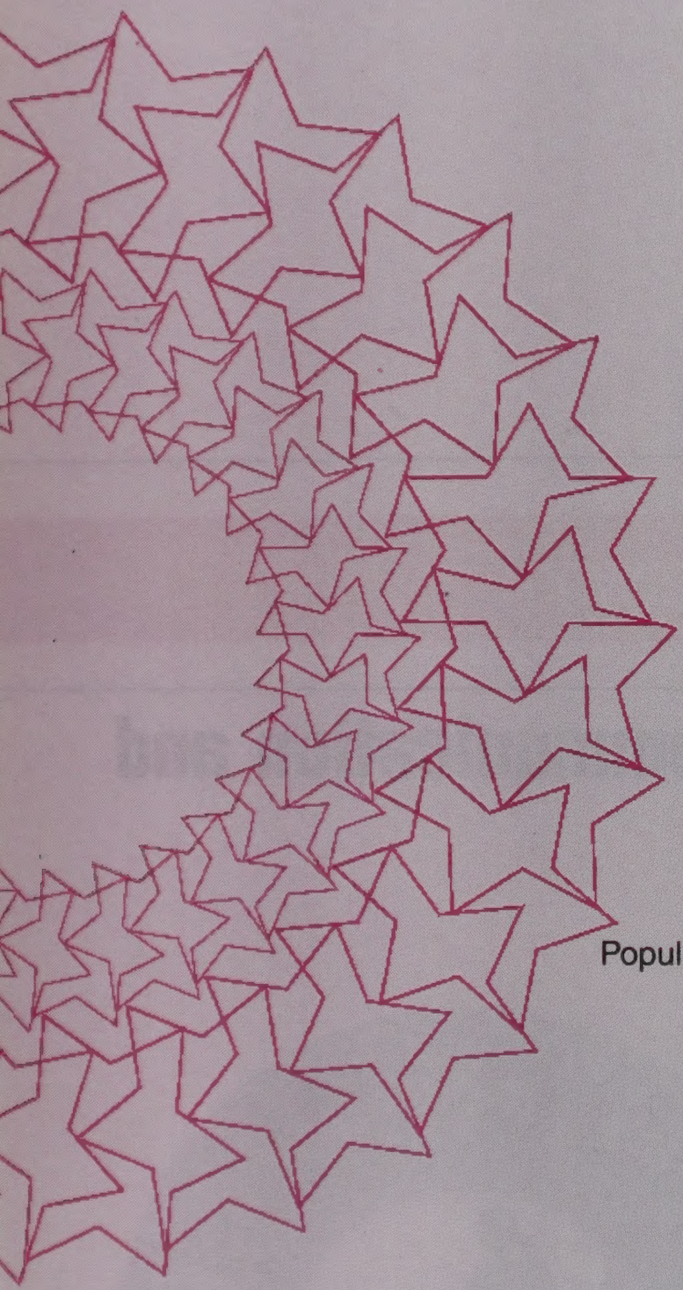
Behaviour Change Communication and Training for Health



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Population Foundation of India (Regional Resource Centre for RCH)
Child in Need Institute
ICICI Centre for Child Health and Nutrition

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Printing
Surya Offset Printers (I) Pvt. Ltd., Raipur
Second Edition: February 2007

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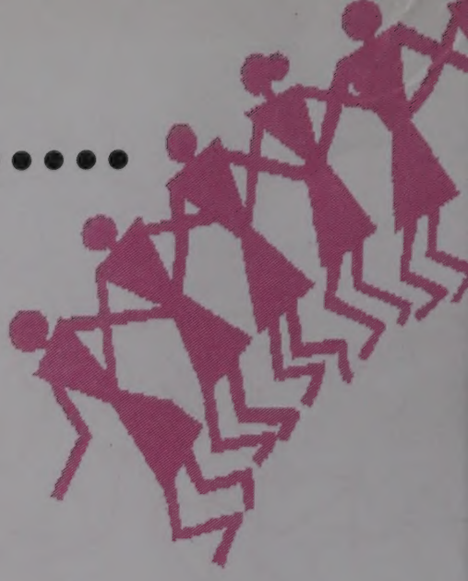
Preface

Public Health Resource Network

The National Rural Health Mission's vision of a national programme planned at the district level, and if possible at the village level, needs an exponential increase in capacities across the board. The NRHM has initiated many steps in this direction. However the nation is vast and diverse. And there are many constraints in existing planning and implementing structures that would need to be overcome. This calls for the official national mission-led process to be supplemented with many varied, creative and massive endeavors at capacity building. State governments, health resource centers, different professional sections and different sections of civil society all need to contribute to meeting these enormous needs of capacity building.

This initiative, called the Public Health Resource Network (PHRN) aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management. The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is not a substitute to formal professional public health training and it does not carry with it any guarantees of increased employment or career options. It is meant to support individuals and organisations both within and outside the health department who are committed to working for a more equitable and effective public health system. This programme complements official training and education programmes through an open-ended, more informal and immediate reaching out with information, tools and a diversity of programme options and perspectives.

The course faculty and editors of the modules are drawn up exclusively from those who have been active in various states in providing support to governments and non governmental organisations in health and related sectors. This programme itself is being organised primarily by a number of agencies already providing resource support to states on different aspects of NRHM programmes.



A Mission needs Missionaries, and it needs them where the challenges are greatest- in the remote and most underdeveloped areas of the northern and eastern states, and indeed in all the under-served areas of all the states. A Health Mission needs these missionaries to also be professionals, where being a professional is not one more form of privilege- but a competence that anyone willing to put in the time and effort – and a little expense – can acquire! Thus the contact programmes at district, regional and state level would evolve into mechanisms of sharing of resources, and building mutual solidarity amongst those who work for change, and of those who work in the health sector because they seek to work for the poor. The true test of the programme is thus not the number of certificates that we issue but the better quality of district plans, a higher motivation of district teams and eventually better health outcomes in the district. The immediate context is the National Rural Health Mission. But hopefully the voluntary network that emerges will contribute over the years to the evolution of a network of district and block level resource groups who provide technical support to all efforts at decentralised planning and decentralised governance and to all societal efforts towards an equitable and just society.

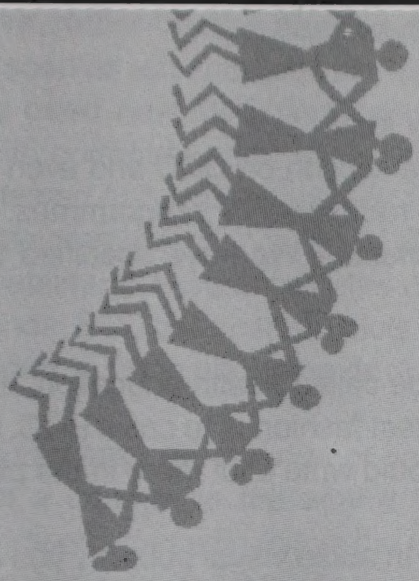
In this book, the fifth volume of the PHRN series, we discuss the approach to both behavior change communication and to the planning of training programmes. In BCC this book grapples with trying to build an understanding of what BCC means and what it means to build a district level BCC strategy – perhaps the most elusive concept in all of health planning. It also briefly introduces the reader to the main principles of planning training programmes at the large scales that district health managements have to tackle.

We plan to update and revise these books, based upon the feedback we receive from the districts. The PHRN looks forward to your learning from these books as well as your participation in the creation of future editions which are enriched by your experience.

Dr. T. Sundararaman
PHRN Programme Coordinator

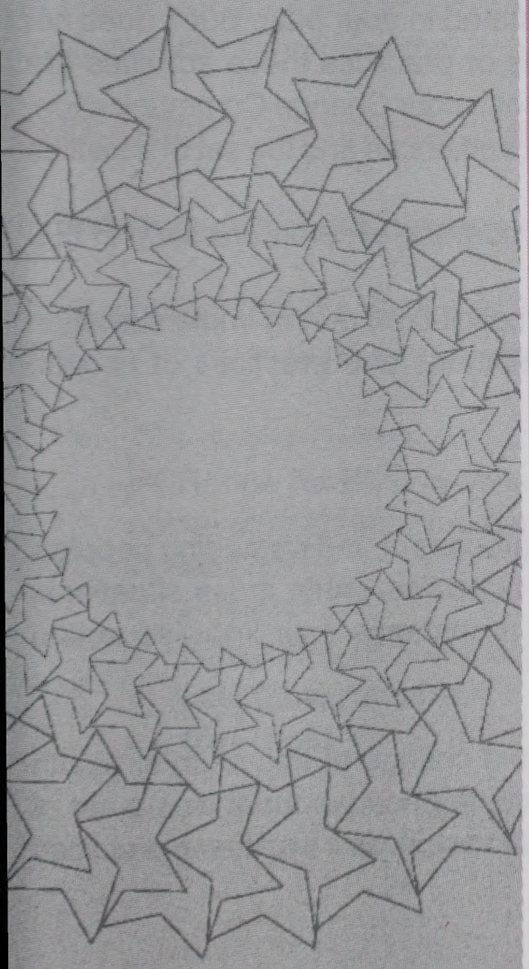
Lesson ONE

Understanding What Behaviour Change Communication Is – and What It Is Not!



In this lesson we shall discuss:

- The difference between BCC and IEC
- What Behaviour Change Communication (BCC) is
- What BCC can and cannot do



CASE STUDY 1

Here is a conversation between a district programme officer and a resource person during a district health planning exercise:

Resource Person: ...Your district plan does not have any BCC strategy in it.
Programme Officer: Did your read it carefully? We have clearly stated a section on BCC and even put in a budget for it. We have planned for posters, folk media programmes, radio and TV programmes. We are going to use audiovisual publicity vans and plan district level *sammelans*. We have specified that NGOs will be playing a major role. So what more can be said?
Resource person: But that is an IEC approach. It is not a BCC.
Programme officer: BCC and IEC - it is all the same. Earlier, it used to be called health education, then it was called audio visual publicity, then IEC programmes and now the latest fashion is to call it BCC. But eventually what we do is all the same. Of course as an academic, you could write a lot more in the plan; tell me what else is to be done.
Resource person: I disagree – all these terms have separate meanings. In audio visual publicity you are only letting people know that such and such a programme exists, or that the achievements of a particular programme are the following things etc. IEC is the acronym for Information, Education and Communication. This states the activities that shall be done, in the way that you have stated in your plan. But it does not specify what outcome is to be expected, or what behaviours, attitudes or practices these activities are expected to change and how. And how will one assess all of these? In Behaviour Change Communication, you would be defining a set of behaviors that need to change in different audiences and the set of activities that would lead to that change.
Programme Officer: That is implicit in what I am saying. After all, the purpose of communication in IEC is to create change in behaviour. This much we know.
Resource Person: But that needs to be explicit in a plan. If it is only implicit then during implementation a lot of activities and expenditures occur but it may not affect the attitudes and practices of people. Rather people do not even look to see whether behavior changed.

WHAT IS BEHAVIOUR CHANGE COMMUNICATION?

Behaviour Change Communication (BCC) can be broadly defined as a process of understanding people's situations and influences, developing messages that respond to the concerns within those situations, and using communication processes and media to persuade people to increase their knowledge and change the behaviours and practices that place them at risk.

It is not just a change of terms. BCC is a term that evolved to express a change of approach to health communication and health education work. This change of approach came because there was a set of concerns about the limitations of health communication and health education work as it was being practiced at a time when it was being called IEC.

In the BCC approach, there is more conscious focus on the receiver—rather than the sender—as the center of communication. Earlier IEC programmes tended to see their purpose as having to "sell" a particular message or idea. The BCC approach recognises individuals within the intended audience as active, rather than as passive receivers of information and messages, who act on messages only if they are seen as advantageous or useful. In the BCC approach there is greater appreciation that the audience may need new skills and social support to make and maintain behaviour change. Most importantly, health communication is one component of behaviour change interventions, which acknowledges that sustained behavior change is effective only when combined with changes in the broader environments. Thus communication in the BCC approach also involves addressing the motivation to change and building the ability to assess benefits of practicing and sustaining new behavior. With such a comprehensive agenda, BCC uses certain tools to communicate information and extend support to the intended participant in order to bring about the desired change in the behaviour.

Unfortunately the change of name for this activity – from IEC to BCC – has been far easier to achieve than a change in the way it is practiced. Thus today we would find a few practitioners of health communication who follow the ideal approach, but are quite content to call their work as IEC. And on the other hand we find lots of persons who state that they are doing BCC programmes, and are yet are never able to go beyond the approach that we have identified with IEC. In the PHRN modules we are referring to a particular approach to doing health communication when we are calling it BCC and this should not be confused with everything that goes under than label.

CASE STUDY 2: BCC STRATEGY IN BANDPURA DISTRICT, CHHATTISGARH

In Bandpura district of Chhattisgarh the BCC plan went like this:

On September 30, the district RCH society received funds for BCC. Earlier they had received funds for BCC under the malaria programme and separately under the HIV control programme also.

- The district CHMO put up three files to the district collector with a BCC plan. One for BCC in RCH, one for BCC in malaria programme and one for BCC in HIV control. In those he showed some expenditure from each programme under the following five heads:
  - Hoardings
  - Posters
  - Kalajathas (Street theatre)
  - Radio programmes
  - Meetings

- These three files were approved.

- He then gave the money for hoardings to an agency selected through the correct approved process. The money for posters was given to a press.

- He got the District IEC officer-in-charge to design posters and the advertisement agency the content of the hoardings. The IEC officer gave the key messages describing the new programmes in the form of a poster design. He used a local artist to make the drawings. The blueprint was approved by the CHMO. Some of the posters and hoardings were on RCH, some on malaria and some on HIV control. Now posters were soon prominently seen all over the district and main block towns and this was appreciated by the officials.

- Then the money for the radio programmes was contracted out to a professional group and the RCH officer was asked to tell them the key issues for the programme.

- The money for the *kalajathas* and meetings was distributed to the BMOs along with instructions that they should organize these activities in their respective blocks and complete it in three months. They were asked to cover messages in malaria and RCH and HIV control, which they did as planned.

- By the end of March all the above activities were completed and the utilisation certificates were submitted. Subsequently in the review of IEC programme officers, Bandpura block was praised as being the best performing block on BCC and a model for others. They were particularly praised for making an integrated plan and for timely completion.

- When asked what were the outcomes the IEC officer said that a lot of awareness of these three areas had been built up especially by *kalajathas*- but did not know whether actually utilisation of services or health outcomes had improved.

DISCUSSION

The above case study illustrated a typical programme. This is what is characterised as the IEC approach and this is what needs to change to a BCC approach.

In the above programme we know what the inputs were, But what were the outputs in terms of behaviour change? Do the programme managers know what behaviours they wanted to change? Were the above inputs the best way of changing these behaviours? Were people convinced by these messages? Did it change their behaviour?

Let us look now at what we expect out of a BCC strategy:

CASE STUDY 3

In March of that year the district IEC officer constructed a workshop for deciding on the objectives of that year's strategy. They decided that in malaria control the focus for the year would be on the promotion of insecticide-treated bed nets while strengthening all aspects of the programme. In HIV control it was to be the promotion of use of condoms and the need for responsible sexual behaviour. In RCH the focus was on promotion of institutional delivery. They asked one group of employees in each block to conduct some village level discussions in four or five villages to understand the following:

- Whether people were using any bed nets and what was their understanding of the cause of malaria and the reasons for not following various preventive measures. Similarly, they investigated what people's perceptions were regarding condom use and safe sex; their stated reasons for their current behaviour and their attitude to the proposed changes and their responses to suggestions for change. Regarding RCH, they understood the community's perceptions and attitudes towards institutional deliveries, availability of services for mother and child health and of both public and private facilities available, people's perceptions about quality.

- Based on this information, the IEC programme team did the following:
  - Identified the intended audience
  - Decided and designed the messages for BCC
  - Decided and designed the BCC tools, channels and forums that would be used

- The final set of activities undertaken in implementing the BCC strategy were the same as in the earlier case study , but there was a considerable difference in the content and in choice of audience to which the messages were addressed and in the decision of what medium was used for what message and where it was to be used. Also there was additional investment in training all the communicators and employees so that in their interaction with the public in their routine work they would be able to provide the necessary BCC inputs in the form of inter-personal communication, small group discussions and meetings. For most employees there was no special training camp organised but a session on BCC was included in all the ongoing training programmes. This was particularly emphasised in the ASHA training.
- The money was then allotted as was done in the case study above. But in addition the communicators were trained in the message and the communication material was standardised and field tested to see the effectiveness of message communication. After the programme the group discussions and survey was done again to see whether there had been behaviour changes, whether more people had started using bed nets, using condoms, and going for institutional delivery.

COMPARE THE ABOVE TWO CASE STUDIES

In terms of expenditure patterns and administrative measures there is little difference between the two case studies. But in terms of outcomes the difference is significant. Unless good administration is complemented by sound technical understanding it does not help. In this case good technical help does not mean doctors or medical inputs. The medical knowledge needed is trivial. It means inputs from public health personnel with correct sociological perspectives, and in-depth understanding of socio-economic determinants of health and health behaviour.

The Changing Approach from IEC to BCC in Health In 1946, the Health Survey and Development Committee, headed by Sir Joseph Bhore recommended the establishment of a well-structured and comprehensive health service with a sound primary health care infrastructure. It was in this context that the concept of health promotion and health education were introduced to achieve desired outcomes. Health education came to be recognised as a vital component of the health care delivery system in India's first Five year plan in 1951. By the second five year plan the focus in health policy had shifted from providing primary health care to the issue of "population control". This was because the high population growth was being used as an explanation for all our social and economic problems- and not being seen as caused by poverty and underdevelopment. This understanding had severe implications on the approaches undertaken in health education, especially concerning women's health. It was within this context that the first 'information, education, communication' (IEC) material was developed. IEC came as a first "educating" campaign for the masses, focusing on providing information of family planning methods and contraception and projecting it as *the* explanation for our poverty. Population education programmes began to be conducted as part of school education and adult education. This health education formed an important component of the preventive, promotive and curative health care provision to the rural populations through an extensive public health system, and was to be delivered by means of not only doctors and nurses, but also through a various categories of health workers. The male and female health workers were intended to provide health and nutrition counseling at the level of the family and local community. But this work got marginalised by the main expectations of her as delivering population control targets. The number of people motivated to accept family planning services became almost the only focus of her work, and the only indicator on which her performance was measured. Later when family planning targets got de-emphasised immunisation and within that pulse polio became the focus. Not only was health education and counseling in the public health system limited to such a small focus, it was one activity on which the worker was not tracked. Even where workers undertook this work they did not have the skills to understand the determinants of behaviours that placed people at greater risk for ill health or were able to contextualise their activities, which were largely limited to information dissemination, to larger socio cultural aspects existing in the community. The inadequacy of counseling skills amongst health workers also emerged as a key gap. This approach towards health communication, known within the system as " driving home a few key messages"

makes for a disease specific, simplistic, and communicator (rather than receiver) centric approach that has got even more strongly entrenched into dominant public health discourse with numerous campaigns for HIV/AIDS awareness and prevention, and related social marketing of contraceptives. (In HIV/AIDS one frequently hears of "the ABC of HIV " that needs to be driven home- A for abstinence, B for Be monogamous and C for condoms- an excellent example of the problem we are describing.) Official documents today recognise the need to strengthen health communication and endorse the need to adopt BCC (for example, the National Health Policy 2002). However changing existing practice remains difficult for an understanding of the problem has been elusive at the level of implementation.Criticism of the earlier approaches to health communication has resulted in development of the term "behaviour change communication" (BCC), but so rapidly is the term BCC becoming associated with persisting past practices that one would not be surprised if there is another change of name a few years hence. The point is to change the way health communication is done – from its current approach to an approach which involves the active participation of the community in directing the design of a strategy appropriate to social and cultural contexts which promotes good health and reduces their risk for ill health.

CASE STUDY 3: FILM ON POPULATION CONTROL

One of the most well known health communication initiative of an earlier generation was a film clip for population control.

The film shows a bullock cart with a poor couple traveling on it. The couple looks rather bedraggled and shabby. Then one child appears on the cart, then another, then another, and then another and so on until the cart collapses. This is then contrasted with the picture of a well dressed person, appearing to belong to the middle class, sitting on a scooter with his wife, also neatly dressed, riding pillion. In front is a small boy, about six years old and behind on the woman's lap is a younger, about two-year old, child. The clip then goes on to show that this family ride happily into the future. The message goes – *"For a happy family limit to two"*.

DISCUSSION

What is the reason for the large family implicit in this visual? What is its relationship with prosperity? What is the image of the small family? The film highlights the perception that an uncontrolled breeding by the poor is the cause of the population problem. It implies that the family would have been happy if it had been small and all that was needed was to control the size of the family -which the poor had failed to do. Is this true? This advertisement is no longer telecast – but this mindset is still widely prevalent.

CASE STUDY 4: BCC STRATEGY TO ADDRESS MALARIA IN CHILKA DISTRICT, ORISSA

When asked what messages on malaria were given to the community, the district officer in charge of BCC activities replied:

"The key messages were:

1. Malaria is caused by mosquitoes and that one should stay safe from mosquitoes.
2. Therefore if one has to avoid mosquito bites one should use insecticide treated bed nets.
3. Also if one has a fever one should take chloroquine the same day – and then take the full dosage of 4+4+2 tablets.
4. Further, the house should be sprayed with DDT."

These messages were not very clear from the community's perspective, and the presentation in the poster was overcrowded, text- and information-heavy. The impact showed that people did not change their behaviours, i.e. they did not adopt the ones that were propagated in the posters.

The district officer explained the reasons behind this failure to change people's behaviours: "Change takes time. Tribal people do not use bed nets – they just do not have the habit of doing so. They are used to being free, and anyway the mosquitoes bite them when they go to the forest to collect produce. So when we give them bed nets they use it for fishing. They are also used to their *baiga's* medicine and will not readily take chloroquine. But change takes time and we cannot expect change so fast. We have to persist."

Meanwhile a small study was ongoing to understand the issues related to use of bed nets for the purpose of district level planning.

(to be continued)

DISCUSSION

The officer's response is typical – a mix of fact and his own beliefs and attitudes – of correct but incomplete understandings.

It is true that tribal populations do not have the habit of using bed nets, but the understanding that this is the main reason for not changing is an assumption influenced by the district officer's own beliefs and attitudes. There were multiple reasons behind people not changing their behaviours - and these were never addressed by this campaign because the approach neither had space for understanding these reasons nor were these reasons considered for inclusion in designing the set of messages.

CASE STUDY 4 (CONTINUED)

In this particular example a study had been undertaken to understand people's behaviours. The findings showed the following:

- People in the concerned tribal villages were well aware of the relationship between mosquitoes and malaria perhaps from previous campaigns. Therefore the first message was not needed.
- The people from the community stated that they were willing to use the bed nets but only a few had been available, and this was not enough for everyone in the household. As the bed nets attracted mosquitoes, the family members who slept outside the net would be more at risk for mosquito bites. As most households did not have beds, but slept on the ground, mosquitoes would often get inside the net.
- The insecticide treatment seemed to have no effect as the mosquitoes were flying around and did not seem to be affected in the least. Therefore, the people believed that the nets were ineffective, and were more useful as fishing nets.
- The people said that when they went to the forest they would get bitten by mosquitoes anyway – so there was no need to use a bed net and protect themselves only at night.
- Choloroquine was often not available – but the *baiga* always was. Besides causing nausea in many people, some who had taken chloroquine had not got cured – similar to the outcome of the *baiga's* treatment - and had died. If one had the risk of dying, the *baiga's* ministrations were anyway needed.

DISCUSSION

The IEC/BCC officer's responses were plausible and even sympathetic – but in effect they were wrong. Not that the community's perceptions were correct. For example, mosquitoes do not die at once when they sit on the net. They die much later when they fly away. Often the insecticide acts only as a repellent. Therefore, it does not matter even if the mosquito bites because the repellent action prevents transmission of malaria. The mosquitoes that bite in the forest are not the same as the ones that transmit malaria. Typically malaria carrying mosquitoes bite only at a specified time of the night. This was something even the officer had not known.

If we accept the tribal people's doubts as justified then we see that their objections to the nets were valid and therefore using them as fishing nets was a sensible decision to make. Similarly, that tribal people are not convinced of the superiority of chloroquine, that they were worried about its side effects and also had poor access – all were valid reasons. Also if chloroquine is not available, such a behaviour change is not feasible because the objective conditions of the new behaviour do not exist.

This case study illustrated the need for what is called "formative research" to define the message content. It also highlights the problem of message content being prescriptive, being unable to understand cultural contexts and being unable to define what is feasible in a given context.

The importance of culture in determining people's behaviours is significant. The fact that the tribal population uses the bed net for fishing, and goes to the *baiga* for treatment are both culturally determined. However, these should not be considered as equal to irrational behaviour shown by the tribal community. The case also illustrates that a poster cannot even address such issues. A *kalajatha* could have been more successful in addressing these issues. However since the exact set of barriers to change of behaviour were not identified beforehand, they were never included as *kalajatha* messages.

WHAT ARE SOME OF THE OTHER PROBLEMS WITH BCC AS IT IS DELIVERED TODAY?

BCC in most public health programmes has followed a formula where dissemination of information is done in a mechanical form. This formula is based on the assumption of a linear and fixed society, where the process of communication is imagined as knowledge flowing from the top, from those who 'know', down along a gradient to those who do not know; where each individual and family acts in isolation and the government or communicator acts as a single source of knowledge and wisdom from which knowledge has to flow down to "educate" the illiterate and "ignorant". This approach has certainly not been very successful at achieving its objectives, but its very lack of success strengthens this framework of understanding. Instead we need to look at health communication having to incorporate considerations of how individual behaviour is influenced by that of the community which they are part of. This implies that neither the individual nor the community is a passive recipient of knowledge but that they can enter into a dialogue with the information received by them. Thus one needs to address the set of values that the community as a group upholds, the perceptions they have of what is the right way of living, of how decisions are made within the group, who makes them and on what considerations, the feasibility of changing such behaviours in the context of both objective factors like the availability of health services and also how much the desired change is at variance with the perception of the community as a whole.

The messages in most BCC programmes have been prescriptive, lacking an understanding of the people's needs or socio-cultural circumstances. Besides they have also been approached with an implicit understanding about the community that we call "victim blaming". People are sick because they are dirty, ignorant, irrational, refuse to listen to reason, superstitious etc. Such an attitude refuses to treat people with dignity and with the principle that they largely make rational choices given the circumstances in which they make them.

Operating on this approach, planners and policy makers have increasingly believed that if IEC has failed it is not because there is a problem with the strategy, but because people, especially the poor, do not listen to reason. This narrow understanding of BCC implies that beyond giving information there is little else that BCC can do. The rest is up to the people, and if they are ignorant and stubborn, it cannot be helped. When such planners do go beyond this sort of BCC- it is to coercion that they turn to. Thus if family planning promotion, such a planner would not question the way the promotion is being done- but rather seek to add coercion – because persuasion is failing. This helps us reflect on the possibility that much of the reason that

health communication persists in the old form is that its intention is often manipulative – that is to change behaviour whether people like it or not – because they do not know better.

Given these attitudes, it seems that we are going to need some major behaviour change of planners and policy makers too!

> **"The messages in most BCC programmes have been prescriptive, lacking an understanding of the people's needs or socio-cultural circumstances. Besides they have also been approached with an implicit understanding about the community that we call "victim blaming".**

Keeping these problems in mind, some of the changes that can be brought about in the BCC strategy are the following:

- BCC should recognise and address people within their social, economic and cultural context with respect as equal, rational human beings, functioning within different frames of rationality that need to be understood and negotiated.
- BCC requires analysis and recognition of what are the current behaviours and their determinants, what behaviours need to change and the **feasibility** and **acceptability** of such changes.

WHAT BCC CAN AND CANNOT DO

Understanding what BCC can and cannot do is critical to conceptualising and implementing the strategy successfully. BCC is one tool for promoting or improving health. Changes in health care services, technology, regulations, and policy are integral to completely address a health problem.

BCC alone can:

- Increase the intended participants' knowledge and awareness of a health issue, problem, or solution
- Influence perceptions, beliefs, and attitudes that may change social norms
- Facilitate building of social/community norms that are facilitative and supportive to desired changes of behaviour/practices
- Motivate and provide the confidence and optimism needed for community action
- Demonstrate or illustrate healthy skills
- Reinforce knowledge, attitudes, or behaviors that are promotive of good health
- Show the benefit of behavior change
- Advocate a position on a health issue or policy
- Increase demand or support for health services
- Refute myths and misconceptions

BCC combined with other strategies can:

- Cause sustained change in which an individual or a community adopts and maintains a new health behaviour
- Overcome barriers/systemic problems, such as insufficient availability and access to health care services

BCC cannot:

- Compensate for inadequate health care or access to health care services
- Produce sustained change in complex health behaviors without the support of a larger programme for change, including components addressing the social determinants of health, health care services, technology, socio-economic structures and changes in regulations and policy
- Be equally effective in addressing all issues or relaying all messages because the topic or suggested behaviour change because the intended participants may have other valid conceptions about the topic or about the objectives of the message communicator, or because such be equally feasible for all families or communities.

It has to be understood that BCC is only one component of behaviour change interventions. The expectations, therefore, of what a BCC programme can achieve needs to be realistic. Human behaviours, including those related to health have complex, multifactorial and interrelated determinants that cannot be addressed by BCC alone, and need social, economic and systemic changes. These issues will be discussed in detail in the following chapters.

Review Questions

1. What are the differences between IEC approach and BCC approach to health communication?.
2. What is referred to as victim blaming in health communication?
3. What are the determinants of health related behaviours?
4. What is that BCC cannot do?
5. Instead of using the term beneficiaries or targets for describing the recipients of health messages in BCC campaign this lesson uses the word "participants". What does this imply?

Application Questions

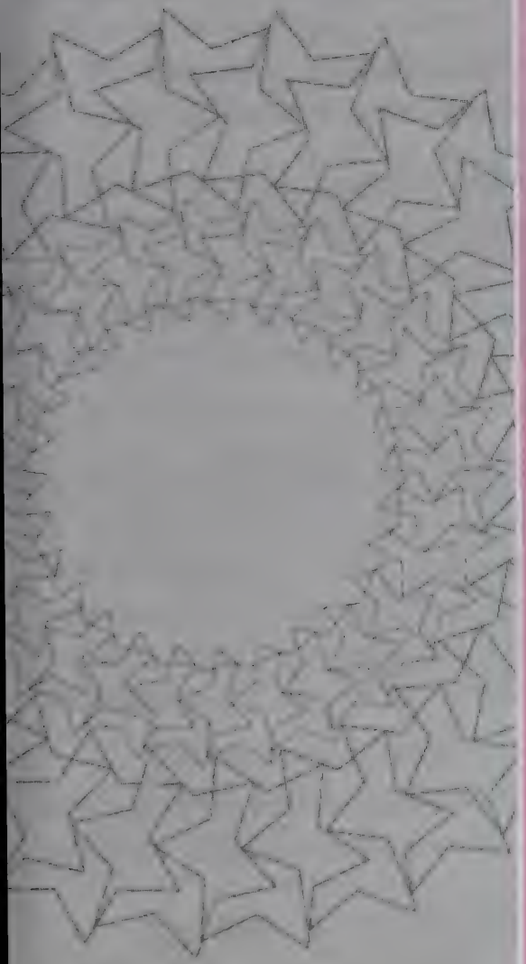
1. Have you come across any other examples of culturally inappropriate or socially insensitive BCC messages? Describe these and explain why you found them inappropriate or insensitive? How would you rearticulate these messages?
2. There are advertisement campaigns that persuade people to consume certain products even though they have no need for it? Can these same tactics work for promoting desired behaviour changes for health considering that these changes are necessary changes?
3. Using the example of improving adequacy of complementary feeds for reducing child nutrition as an example discuss – the social and cultural contexts of behaviour change and the feasibility of behaviour change. There has been much IEC work on this issue. But are there are any examples of how this has been influences by considerations of contexts or feasibility.

Lesson TWO

District Behaviour Change Communication Strategy as part of the district health plan

In this lesson we shall discuss:

- The key elements of a BCC strategy and BCC implementation framework
- The key components of a district BCC strategy
- The skills and tools to construct the mix of audience- message- media- communicator and indicators needed to make a BCC plan
- The institutional and capacity building requirements of a district BCC plan
- Building norms for a district BCC budget



THE BCC STRATEGY FRAMEWORK

The importance of theoretical structures for a planning process should be recognised. District Planning proceeds under an overall 'theoretical' understanding of a BCC strategy, which we need to make explicit.

The strategic objectives of BCC may be stated as follows:

- Empowering the family and individuals to take health related decisions based on information and analysis.
- Motivating the community to play a proactive role in improving their health status.
- Effecting greater utilisation of health services through an improved public understanding of health care.
- Creating competencies and enabling environment to assist with the above objectives.

The first objective 'empowering the family and individuals to take health related decisions based on information and analysis' involves creating awareness of health needs and determinants of health as well as the information and skills to prevent and manage common illness and seek appropriate care in a timely manner. This objective refers to decisions that are taken at the family or individual level.

The second objective 'motivating the community to play a proactive role in improving their health status' recognises the way that behaviours are determined by the collective – at the community level – and looks at various aspects of social mobilisation to be able to affect change of behaviours. Here, in addition to information transfer, creating an enabling social environment for change becomes very important.

The third objective relates to a significant aspect of community and individual behaviour – their pattern of health seeking – and seeks to influence this by building a shared community level understanding of health care. This involves knowing about the services that are being delivered by public health system facilities, as well as about the services that the facilities are mandated to deliver, the expectations the public can have of health care providers and health care systems, and about their constitutional rights and entitlements in this regard.

The fourth objective is reflective, and relates to the skills and competencies of personnel involved in such communication work and on the integration of communication strategies with the district plan. It also emphasises the creation of networks and partnerships and coalitions with different individuals and organisations who share these objectives and above all on influencing the availability of health services and social circumstances so that such behaviour change is feasible. 'enabling environment for change' would also require behaviour changes on the part of health care providers, as well as a strong public health system delivering its mandated services.

(For a more detailed delineation of BCC strategies do write to the PHRN office or visit the website. The Chhattisgarh document on BCC strategy is a very useful theoretical reference point for the strategic overview.)

THE IMPLEMENTATION FRAMEWORK

Mere knowledge of behaviours and approaches to changing them will not suffice in being able to construct a district plan. The district plan will need to look at behaviour change as a process that takes place within a certain framework of implementation.

The Implementation Framework

Key Components:

- Message, Media and Communicators
- Monitoring, Evaluation and Feedback
- Institutional Structure and Functions
- Capacity Building
- Management
- Budgetary Aspects

The key components of such an Implementation Framework are:

- **Message, Media and Communicators**
  - What are the behaviours that need to be changed?
  - For a particular behaviour change:
    - What are the messages that would be used?
    - To what audiences would they be addressed?
    - Through what media would these messages be conveyed to the audience?
    - Who would be the communicators?

- **Monitoring, Evaluation and Feedback**
  - How would we monitor whether communication activities are occurring as per plan?
  - How would we assess whether the activities were effective in changing behaviours?
  - If they were not, where was the bottleneck? Was it that messages were not conveyed effectively? Was it that though information was conveyed it could not effect a change of attitude? Or was it that though attitudes changed, there were objective constraints that made the change of behaviour not feasible?

- **Institutional Structure and Functions**
  - What are the current institutions playing a role in BCC work in the district and sub-district levels?
  - How would they be supported by state level institutions?
  - What roles are envisaged for them in the plan?

- **Capacity Building**
  - What are the current capacities in the district to plan and implement a BCC plan?
  - In what areas would capacities need to be built?
  - Can organisations with adequate capacity for planning or for undertaking different aspects of implementation be brought in from other districts or the state level to enhance available capacity within the district?

- **BCC Management**
  - Who would be in charge of or accountable for these activities?
  - Who would coordinate all the above aspects and how?

- **Budgetary Aspects**
  - What are the resources available?

Even where district planning is done the current practice is to equate strategy with only conveying information and implementation relating to institutional structures and functions. Although we note that the bulk of the planning does relate to these aspects, and that these are the elements of the plan that change every year, the other aspects of the implementation framework need to be emphasised as well.

MAKING A DISTRICT BCC PLAN

Let us now consider the approach to drawing up an annual district plan. We describe it as six steps:

1. Identifying key behaviours that need to be changed, and analysing their determinants.
2. Stating the mix of audience- message- media and communicators.
3. Deciding the monitoring and evaluation strategy – especially the indicators that help us assess whether communication occurred and whether it was effective in securing behaviour change.
4. Deciding the institutional and management framework for the plan.
5. Deciding the plans needed to build capacity to implement this plan.
6. Deciding the budgetary requirements.

1. Identifying Key Behaviours and their Determinants

- Decide what behaviors the BCC plan would be focused on in the current year. To determine what would be the behaviours addressed we would need :
  - To know the *programme priorities* addressed in the district health plan and to what extent changes in behaviour are needed to address these priorities (along with other changes in service delivery).

- To receive *formative research* inputs that help us understand current behaviours and their determinants.
- To have with us *feedback/evaluation* of earlier BCC programmes so as to understand what worked and what did not.
- To organise *participatory workshops* so as to benefit from inputs of those implementing programmes and those members outside government who are interested and aware of the health situation, the problems and needs – which would largely be with NGOs, but also with Panchayats, farmers associations, cooperatives, self-help groups, and other community based structures.

2. Deciding the Mix of Audience, Message, Media and Communicator

This has the understanding that each one of the above four components is inextricably linked to the other. The audience group to be addressed determines the message chosen. The message chosen influences the choice of media and the choice of media influences the choice of communicator. This is why we recommend the use of the following grid for planning the effective mix of audience- message- media and communicator.

Given below is a grid for three different aspects of a district BCC plan - preventing early marriage of girls, improving child nutrition, and combating alcoholism:

PROGRAMME OBJECTIVE: PREVENTING EARLY MARRIAGE IN GUMLA DISTRICT, JHARKHAND

AUDIENCES: PARENTS AND GRAND PARENTS OF ADOLESCENT GIRLS ESPECIALLY SCHOOL DROP OUTS FROM CLASS 5TH TO 11TH
JATTEE PANCHAYAT MEMBERS, RELIGIOUS HEADS, *CHADEEDAARS* ETC. ESPECIALLY AMONGST PATEL, KURMI AND SAHU COMMUNITIES

Behaviour Change needed to result that	Key factors that would influence behaviour change	BCC Activities
Parents of young girls do not seek to fix match for daughters below 18 years. Parents of young boys do not entertain proposals for marriage for sons below 21 years Girls are not married off before completing 18 years and boys not before 21	▸ Understanding current rationale from the community's perspective ▸ Awareness on the disadvantages of early marriage for girls and also for an underage couple and their children ▸ Awareness about reasons for fixing the legal age of marriage ▸ Skills in motivators and decision makers to withstand family, neighbourhood pressure ▸ Motivation through recognition as progressive and responsible parents- to nurture and protect instead of punishing by marrying off the children at a young age ▸ Encouragement for the girls to pursue school education/ a vocational course/ skill building to participate in family or other occupation	▸ Focused Group Discussions with different population groups to understand the reasons behind this practice and discuss solutions in a participatory manner. ▸ ASHAs, AWWs and ANMs to conduct such discussions in all hamlets. ▸ Organising Shows of local art forms particularly *bharthari / pandwani* and folk media – at least one in every village – more often in villages with a greater incidence of early marriages ▸ Including inspirational stories in school text-books or as a supplementary lesson distributed to schools as an immediate measure. ▸ Advocacy through SHGs especially at the time considered auspicious for fixing marriages and post-harvest seasons Inclusion of appropriate messages related to this theme in TV/ Radio programs ▸ Sensitisation of Jaatee Panchayat members/ leaders and recruiting and facilitating "champions" from amongst them for the cause. ▸ Posters at community halls, panchayats etc ▸ Discussions and debates – *"Swasthya ke sawaal aur aapke khayaal"* ▸ All above activities with equal involvement by DWCD.

Indicators	Indicators	Indicators
▸ Reduction in number of marriages below 18 years of age compared to last year/ season	% of families in a sample of families surveyed who are: ▸ able to list different disadvantages of early marriage ▸ agree that early marriage is detrimental to the health of women and their children ▸ give correct responses regarding parents' responsibilities for a girl's marriage. ▸ motivating girls for learning vocational or other skills. ▸ Able to negotiate with family, neighbourhood and community at large to withstand the pressure for early marriage of self or in the family	▸ Number of focal group discussions held. Number of people trained for such discussions. ▸ Messages incorpo-rated in folk art performances ▸ Inclusion of stories in text books through SCERT/local supplements ▸ Development of and timely use of posters at stipulated places ▸ Number of and timing of *sammelans* of Jaatee Panchayats where the issue was discussed ▸ Incorporation of appropriate messages in radio/ TV ▸ Programmes ▸ Meetings and joint planning with DWCD

PROGRAMME OBJECTIVE: IMPROVING CHILD NUTRITION IN BOLANGIR DISTRICT, ORISSA

(Note from a large number of possible behaviour changes that may be needed, research had come to focus on only one as so critical that it was decided to bring entire focus of campaign on this single issue for the coming year)

AUDIENCES: **PRIMARY - MOTHERS OF UNDERNOURISHED CHILDREN UNDER 1 YEAR**

SECONDARY - FATHER OF THE CHILD, MOTHER IN LAW AND SISTER IN LAW

Behaviour Change needed to result that	Key factors that would influence behaviour change	BCC Activities
Families start giving locally available complementary food in adequate quantities and quality at least 5 times a day from 6 months of age onwards besides breast milk	▸ Belief that child does not need food other than mother's milk till a year or later. Underestimation of the food needed. ▸ Belief that child is unable to consume more- and the need to increase frequency rather than quantity per feed to overcome this not being known ▸ Fear that introduction of food will cause diarrhoea and lack of skill in dealing with the situation ▸ Inadequate knowledge about nutritious value of various food ▸ Belief that nutritious food is expensive. ▸ Food related taboos and concept of hot and cold food items. A taboo against giving fats and oils to young children. ▸ Absence of enabling environment for the mother to take decisions and therefore decreased feasibility of the change (time mother can spend on feeding and child care is limited, ability to keep snacks secure for only the infant within family structure)	▸ ASHAs, AWWs and ANMs need to visit all mothers with children between 6 to 9 months to observe and find out about their knowledge and behaviour understand their constraints ▸ One to one counseling for mothers not practicing/ planning to practice the recommended behaviours, especially on how to secure frequency of feeds and fats and oils for the child, within her social circumstances. ▸ Special meetings with mothers in law / sisters in law to discuss food taboos and child caring practices ▸ Sensitisation of the father through leaflets designed for the purpose ▸ Folk media like plays, to organise skits on this theme with focus on winning consensus for overcoming constraints and creating an enabling environment ▸ Radio jingles on feeding five or six times and giving fats and oils.

Indicators	Indicators	Indicators
▸ % of mothers with a child in the age-group 6 to 12 months who report having started complementary food ▸ The frequency and variety of food given to the child in last 24 hours in compliance with the recommended behaviour	▸ No. of mothers of children in 5-12 months of age able to tell the correct age to begin complementary food, type of food to be given and frequency and quality especially inclusion of fats and oils ▸ No. of mothers/ sisters in law/ fathers who approve that giving complementary food at this age is beneficial for the child ▸ No. of families where that understand that achieving this behaviour change needs the entire family's support and is not just the responsibility of the mother.	▸ Number of health/ICDS functionaries trained in counseling with reference to this theme. ▸ No. of counseling visits made to households during the previous months in which the above messages were discussed ▸ Content and quality of leaflets produced ▸ Video Documentation of the folk media programmes to see how effectively key messages are communicated.

Discussion

- We can include community leaders, religious leaders and a number of other individuals/groups in the audience - but it was consciously decided to limit the audience to these groups. Would you agree? Who are some of these individuals/groups that exert significant influence on child feeding and caring practices, thereby determining their nutritional status?
- In the above example a single behaviour has been isolated but is then being addressed with multiple channels of communications and multiple messages. This is in contrast to current practice of addressing a number of issues with a single message for each. The former approach is considered superior to the latter approach. Would you agree?

PROGRAMME OBJECTIVE: REDUCTION IN ALCOHOLISM - KORIYA DISTRICT, CHHATTISGARH

AUDIENCES: ALL RURAL PEOPLE ESPECIALLY ADOLESCENTS AND THE YOUTH

Behaviour Change needed to result that	Key factors that would influence behaviour change	BCC Activities
Restrict alcohol consumption below alcoholic levels Alcohol related family violence is not accepted within the family and neighbourhood Limited alcohol consumption at high risk times like festivals	▸ Information about health risks of alcohol and the levels of consumption where it becomes dangerous ▸ Information about the link between alcoholism and decrease in work productivity and rise in domestic violence ▸ Skills to differentiate between tolerable levels of alcohol consumption as norm of "acceptable behaviour" within the cultural context ▸ Skills for stopping such alcoholism and alcohol induced disruptive behaviour in the family ▸ Zero tolerance for alcohol related violence. ▸ Decreased ease of availability and access to alcohol. ▸ Restriction on total amount of alcohol that can be brought in for a festival.	▸ FAQs in form of a pamphlet accompanied by audio cassettes of *Kissa* /songs depicting the risks and effects of alcoholism to be distributed/ played at all *mela madhais/ haat bazaars* ▸ Testimony videos as TV programmes ▸ Tin boards at *mandees*, bus stops and local liquour shops with emotional-poetic- appeals and questioning peer perceptions that encourage alcoholism. ▸ Structured facilitated mandatory discussions with women's groups/SHGs/ panchayats and youths kendras ▸ Community mobilisation through self-help groups and women's health committees against alcoholism and related behaviour. Meeting as of families where there has been alcohol related domestic violence. ▸ Community action e.g. breaking of all alcohol pots and voluntary abstinence for a month in the whole hamlet if in any family has experienced alcohol related domestic violence. Also, individual penalties can be imposed- where there is an unanimous decision in the SHGs to play a monitoring role and to impose penalties ▸ Special outreach to youth before festivals

Indicators	Indicators	Indicators
Reduced episodes of alcoholism related domestic violence in identified families	▸ Able to tell the risks associated with alcoholism ▸ Recount associated behaviour observed in family/ neighbourhood ▸ List steps to be taken to stop such behaviour	▸ No. and quality of printed and audio material conveying this message ▸ Coverage of *mela madhais* through FAQ pamphlets and audio tapes ▸ No. and placement of tin boards ▸ No. of village level meetings held to discuss issues related to alcoholism. ▸ Number of incidents of domestic violence and other disruptive behaviour responded to as a group. ▸ Discussions on voluntary restrictions.

Discussion

This was not a part of an official BCC plan, but is based on action that was undertaken in Koriya district, led by Mitanins and NGOs even though there was no plan!

Could such an action be planned for in your district – what would be the problems? What about legalities?

In community mobilisation there is a hierarchy of actions- each activity builds an enabling environment for the next level of activities. Are issues like alcoholism or violence against women ever addressed in district health plans? What is the relationship between BCC and Social Mobilisation in this plan?

The above grids can be meant to be used as a template for planning BCC activity in the district. But there is a process involved in filling up the columns- if planning has to have a scientific basis.

3. Monitoring, Evaluation and Feedback

The key issue in monitoring is the identification of appropriate indicators to be used.

In the above tables we have given an example of indicators to be used in three different cases and the means of verifications of these indicators. Note that there are two types of indicators:

On the last column are indicators that indicate whether the activity proposed actually took place with some understanding of how much of it took place.

In the third column there are another set of indicators which relate to immediate outputs. Thus if a communication activity took place – we need to know whether the information that was to be conveyed was adequately conveyed.

In the second column is the outcome indicator- whether the desired behaviour change was actually achieved.

Let us focus on one example to understand this.

AUDIENCES: PRIMARY - MOTHERS OF CHILDREN UNDER 1 YEAR, WHO ARE UNDERNOURISHED

Behaviour Change needed to result that	Key factors that would influence behaviour change	BCC Activities
Families start giving locally available complementary food in adequate quantities and quality at least 5 times a day from 6 months of age onwards besides breast milk	▸ Belief that the child does not need food other than mother's milk till a year or later. Underestimation of the quantity of food needed. ▸ Belief that the child is unable to consume more - and the need to increase frequency rather than quantity per feed to overcome this is not being known	▸ ASHAs, AWWs and ANMs – building the understanding of these communicators ▸ One to one counseling with mothers and other key family members.

Outcome Indicator	Output Indicator	Process/Activity Indicator
The frequency and variety of food given to the child in last 24 hours in compliance with the recommended behaviour	▸ No. of mothers/ family members of children in 5-12 months of age able to tell the correct age to begin complemen-tary food, type of food to be given and the frequency and quality of feeds, especially the inclusion of fats and oils	▸ Number of functionaries trained in counseling mothers/families with reference to this theme. ▸ No. of counseling visits made during the previous months in which the above messages were discussed ▸ Content and quality of leaflets produced

In the above example, output indicators, let us know whether the BCC activities took place. If, for example, ANMs or ASHAs were not trained on what is expected of them we can hardly blame the rest of the strategy, much less the people for a failure to change behavior. Also we want to know whether counseling visits happened.

During monitoring, this information can be got by just asking the ANMs or AWWs or ASHAs in the review meeting and noting down their response.

Cross-checking this can be done by comparing the reports of the different functionaries or visiting a cross-section of houses and finding out what was happening in the last month.

Process Indicators, let us also know whether the processes took place and whether they had sufficient quality. Thus, counseling visits could have happened, but if the families do not even know the key messages then obviously the process was of poor quality to make any difference or the process report was not true. Thus if the training of the ASHAs had been of poor quality or if their visits were not made with sufficient skills and motivation, then the counseling would be of inadequate quality. Process indicators are meant to assess this.

Process indicators are difficult to assess from just functionaries reports. But they would need to learn to do this – or else quality would never improve. Thus strategies of monitoring usually call for implementers to report on outputs with cross-checking where appropriate. However the cross-checking report is more important and often is what one relies on mainly.

Outcome indicators, let us know whether the sum of outputs were adequate to change behaviour. They reflect not only on programme implementation but also on programme strategy. Thus communication could have been effective but the behavior change may not have been feasible due to other factors. In such a case the output indicators would reach desired levels but the outcome indicators would not outcome indicators are usually not possible to obtain as part of monitoring. They need evaluation. The evaluation could be mid-term or it could be end-term; it could even be concurrent. It could be an internal or external evaluation. Usually a sample survey would be required or well applied qualitative techniques like rapid appraisals or focused group discussions.[1]

Other than indicators, monitoring requires to define frequency of collecting this information, who would collect each information, how it would flow, where it would get analysed and how it would feedback into programme management. Seldom can a programme have separate staff for carrying out activities, a separate cadre for training, a separate cadre for management and yet another for monitoring. Thus, monitoring is usually a function of a particular cadre with only those analysing the data at district and state levels being full time on monitoring.

So these questions of a BCC plan would be integrated with the programme management plans.

Evaluation feeds into programme design, programme planning and also implementation.

4. Institutional Structures and Programme Management

District Level

The District Health Society would have a district BCC sub-committee to make the BCC plan and implement the BCC activities.

Who are the human resources available who either due to their other work allocation and its centrality to BCC should be part of the BCC committee?

1. Programme officer: Ideally at least one of the four programme officers of the district should have been trained in health communication and such a person should chair this committee
2. District IEC officer: where there is such a post should be the convenor of the committee.
3. District training center programme staff: would also all be trained to function as committee members.
4. The Block Extension Educators (renamed BETO) have this as their main function and are central to block level implementation and they should be on it.
5. District resource persons of the ASHA programme would also be members of this committee- as the ASHA programme would be a major contributor to any health programme implementation.
6. Two or three non governmental representatives who would provide technical support due to their experience in BCC and should be there especially if they can provide professional BCC inputs.
7. In case there is no professional expertise in BCC in the district an identified state level technical agency or NGO earmarked to provide support for each district should provide a person to provide such inputs into the planning process.

This committee may meet as and when needed but perhaps not less than once in a quarter. The most active and capable five or six members of this committee can form a task force who would do the studies and undertake the programme planning and monitoring, meeting as often as necessary to achieve their tasks.

Location of the district IEC officer and the committee's offices may be at the district training center or in the district health mission/Chief Medical Officer's office – whichever is able to provide the dynamic environment and the space for it.

Block Level

The Block Extension Educator or equivalent officer is usually the convenor and all the supervisors are members of the block BCC team. The BMO leads this team. Block resource persons of the ASHA programme and civil society active in those blocks may also be included in this team. If the NGO has the ability they could even convene and manage the entire BCC plan for the block.

Largely, team training would be organised at the block level to promote a shared understanding of health communication and a team approach to communication related work. The important thing to note is that at the block and even more peripheral levels, BCC has no separate cadre. It is a function of all cadres with some playing more active BCC roles.

Let us examine these roles and the capacities that are needed.

Institutions	Functions	Competencies
BEE and the block health management team	• Support the District IEC subcommittee in all its functions. • Implement the district IEC plan as appropriate for the block. • Implement on the job capacity building of ASHAs/, Dais, ANMs, AWWs, MPWs in Interpersonal communication and other forms of BCC in synergy with the DTC. • Collect feedback from the field on the campaigns, initiatives and interactions with the community. • Help the district design context specific messages and material. • Maintain necessary block-level databases, especially tracking the beneficiaries of different schemes for using them in advocacy.	Co-ordinating tasks, prioritizing, organizing and problem solving; Using basic PRA; Using different media, including mass media; Facilitating and monitoring health communication activities; Working with different groups – low literacy/ gender/ ethnicity/ school children / adolescents/ youth/ elders; Negotiation counselling and consensus building;

Gram Panchayat, Village & Hamlet Level

At the Panchayat level the BCC work is integrated with all health planning and implementation work needs to be integrated through the statutory Panchayat health committee. The ANMs, Anganwadi workers and the trainers of ASHAs, besides themselves carrying out BCC activities, will provide technical support to these committees. At the hamlet level the women's health committee and /or the self help groups play the role of communicators along with the ASHA. The ANMs and the ASHA trainers and ASHA will together provide training and support to the local community based organisations and to the Panchayat health committees.

Institutions	Functions	Competencies
ANMs, MPWs	▸ Carry out the planned health communication activities ▸ Collect feedback from the community and share it with the Supervisors and BETOs ▸ Train and support the ASHAs/Mitanins in carrying out IEC / BCC activities	Participatory Rural Appraisal; Counseling and consensus building; Using basic communication aids;
ASHAs	▸ Play a proactive or supportive role as necessary to disseminate health messages ▸ Undertake community mobilization ▸ Network with women's groups/ SHGs and involve them in advocacy ▸ Share local knowledge with ANMs, Supervisors, BETOs, help them understand the target audiences and learn out about the local context and culture	Working with different groups; Using basic communication aids; Motivating, mobilising and engaging people;
SHGs, women's health committees and other community based organisations	▸ Play a proactive role to disseminate health messages and engage with community on building understanding current behaviours and needs for changes. ▸ Undertake collective action that involves many individuals and families to support or catalyse changed behaviour.	Understanding of issues, current behaviours and need for changes. Understand needs and methods of social mobilisation.
Panchayat statutory committees	Integrate BCC into health plans by identifying key behaviours that need to be addressed. Support activities and provide leadership for changes.	Understanding of issues, current behaviours and need for changes. Understand powers and influence of their office and learn how to exercise it to support BCC.

5. Capacity Building

Capacity building is to be seen as more than training. Capacity Building should involve

a) Enhancing the knowledge
b) Strengthening skills,
c) Making technology available and accessible
d) Enabling management practices and policies.

Capacity building measures must not be limited to preparing personnel to perform current functions but must also prepare them to perform future functions especially given the fast changing communication scenario and technologies.

The capacity building needs that exist at different levels for implementing the strategy relate to:

- BCC planning and management
- Design and development of appropriate Communication Material
- Training methodologies for development of health communication skills.
- Enhancing communication skills using different media , especially for communicators in that medium
- Event management
- Evaluation, supervision and facilitation
- Reporting and Documentation& Communication Research.
- Participatory methodologies for involving communities
- Negotiation & Advocacy

Once the other elements of the plan are made it is easier to spell out capacities that would be needed and in whom.

6. Budgets

Budgeting for a district BCC plan has four aspects:

- Knowledge of the resource envelope available.
- The costs of the activities planned- taken as activity packages- so that it is critical to creating behaviour change.
- In view of the resource constraints, activity packages would get prioritised. This should keep in mind also that activities that directly reach communities and families and are more focused should get more priority and there should not be an over expenditure of centrally expended items like hoardings and posters and mega-events, that are relatively easier approaches if reaching

expenditure targets is the main goal. These latter are not only low in effectiveness – they are sites of considerable leakage of funds- and acts as an environment to keep BCC in such a poor state of planning.

- Sources of funds to close the gaps – especially the possibility of sponsorships by private sector and community support for community level activities.

Norms for budget allocation

We suggest below a budgetary norm that could be used for planning the resource envelope. Please note – this is not a government guideline. It is only a suggestion that the state could usefully use such a method for its budgetary allocations and ensure that though the district plan is made autonomously it still conforms to minimum standards . We have put it up in the language and style of a note-sheet put up for release of funds from the state programme manager to the districts.

MODEL NOTE-SHEET

1. The total budget for the state for BCC activity from all sources is _____
2. The districts could be allocated funds @ Rs. 2 to Rs. 3 per capita for BCC activity for non-tribal and tribal districts respectively. Thus a tribal district with 10 lakh population would have an allocation of Rs 30 lakhs funds for BCC. This could be increased of the fund available increases. The exact sum of money to be sent to each district health society based on this norm is annexed.(flag A).
3. Within this the district may be permitted to make allocation for various sub-heads as follows:

Sub-heads	Rate per capita
Material development and production	Rs. 0.50
Capacity building	Rs. 0.35
Activities and events at the community level	Rs. 0.50 (non-tribal districts) Rs. 1.00 (tribal districts)
Activities/ Hoardings / events at the district level	Rs. 0.25
Monitoring & Evaluation / Programme management/Support to community level activities	Rs. 0.45 (non-tribal districts) Rs. 1.00 (tribal districts)
Total	Rs. 2.00 (non-tribal districts) Rs. 3.00 (tribal districts)

4. Any deviation from the above norms is acceptable and welcome. However, the pre-requisites for such deviation would be that the district should make a presentation to the State IEC/BCC co-ordination committee in its full meeting. This committee would have the powers to approve this deviation and the minutes of any discussion on the deviation would be duly recorded. This is simply to ensure that the central expenditure on publicity intensive activities like hoardings and events remain within the ceiling. (We cannot do away with the legitimate right of governments to seek publicity for their programmes and achievements – but we do need to ensure that this goal does not replace the goals of BCC). Also we need to keep material production costs at a reasonable level.
5. Mass media like films, TV and radio production will be undertaken at the state level and the budget for this would be provided at the state level over and above what is shown in the above allocation.

The above proposal may be approved.

State RCH Programme Manager

State BCC officer-in-charge

Review Questions

1. What are the key components of an implementation framework for BCC?
2. What is formative research and how does it contribute to BCC?
3. What are the institutional mechanisms suggested at the district and block level for BCC?
4. How does one decide the mix of audience – message- media and communicator for a particular behaviour change?
5. What would be the budgetary allocation to different heads of the BCC budget? Is there any way in which you would like to modify this. To state with reasons.

Application Questions

1. One could work out the mix of audience- message- media – communicator in a number of areas. Could you choose an area where there is formative research available on behaviour and its determinants and using that information draw up a table as done in the examples given above? Include indicators also.

Project Assignment

1. Examine the existing district plan for its BCC programme. See what elements of a comprehensive strategy are missing and what are present.
2. Identify key issues for BCC work in the coming year. Make a district plan using the planning template given in the lesson.

1. There is a complete chapter on indicators in module 10 which is on district health planning.

Lesson THREE

Designing a District Specific BCC programme

In this lesson we shall discuss:

- Identifying and understanding health related behaviours and their determinants
- Identifying intended audience
- Identifying the key message points
- Choosing channels, tools and forums for communication
- Common behaviours and the best audience-behaviour-tool-forum mix/message-audience-communicator-media mix

IDENTIFYING AND UNDERSTANDING HEALTH RELATED BEHAVIOURS AND THEIR DETERMINANTS

From case studies in the previous chapters regarding the reasons behind success or failure of BCC initiatives for malaria and family planning, it is clear that identifying and understanding the concerned behaviours and their determinants is of utmost importance. BCC plans formulated in the absence of such an understanding have the risk of being contextually irrelevant or even insensitive in certain cases. Before deciding on the BCC messages and channels, it is essential to carry out a process of understanding the health behaviours of the community, and their overall sociocultural and economic realities. When this is not carried out properly, efforts can be wasted, persuading people to change behaviours that are harmless or failing to influence the behaviours that really could have an impact on the health issue.

While behaviours of individuals, groups and communities are important determinants of their health, the factors that influence behaviours frequently lie outside the individual's control and are influenced by economic, social, and political factors operating at the district and national levels.

Therefore, the factors that determine health behaviours can be divided into three:

1. Individual factors that are at the individual or household level
2. Social and cultural factors that are at the community level
3. Enabling/structural factors that are at larger systemic levels

CASE STUDY 1

Chilka district in Orissa is a malaria endemic area, comprising mainly of fishing communities. The IEC officer in the district was faced with a major problem – the communities did not use the insecticide treated bed nets and chloroquine that were distributed to address the problem of malaria.

An analysis of this behaviour in the community shows the following determinants:

- The communities were not aware of the etiology of malaria. The knowledge that malaria is caused by mosquito bites was not common, and therefore, they did not see the correlation between the use of a bed net with prevention of the disease.
- The traditional knowledge in the community associated the symptoms of malaria – high fever and chills – with evil spirits that affect the person at night. Therefore, they preferred to visit the baiga when they had these symptoms rather than take chloroquine tablets.
- Due to the high cost of fishing nets, which some households could not readily afford, they had to use the bed net for fishing.

The bed nets were not supplied after the first batch, and there were not enough nets for all members of the household. Similarly, the ANM often ran out of chloroquine tablets and people had to come back without getting their dosage from the sub centre.

DISCUSSION

The determinants of the community's behaviour of not using bed nets and taking chloroquine are complex and are at different levels. While knowledge and awareness about the disease are individual factors, the associated superstitions and visiting the baiga are community level factors. The use of the bed nets for fishing due to extreme poverty and the unavailability of bednets and chloroquine relate to larger systemic factors.

It is important to understand these determinants, as they would influence the design of the intervention programme to address the problem. For the community to change their behaviours, the IEC officer, therefore, has to design messages to give factual information about malaria and its causality, attempt to dispel related myths and superstitions, and ensure that bed nets and chloroquine are available at the health facilities.

IDENTIFYING AND SEGMENTING THE INTENDED AUDIENCE

After understanding the determinants of the specific behaviour that we are attempting to change through health communication, it is important to identify who is manifesting that behaviour in the larger community. For example, if we want to increase health seeking behaviour of the community to increase child immunisation, we need to identify who takes the child to the health facility for vaccination. In this case, as in most other child caring aspects, it is the mother. The BCC programme can therefore, identify mothers of young children in the community as its intended audience.

However, identification of audience may not be so simple. Take the same case of child immunisation. A BCC programme is designed and all messages are directed at the mothers to change their behaviours and take their children to the sub centre and the Anganwadi centre for immunisation. However, the turnout is not very large. An analysis of the situation shows that even though most mothers knew that their child needs to be immunised, her mother-in-law was not aware of the benefits of immunisation. She argued that in the old times people did not immunise their children. Infact, even her son was not immunised. She felt that it will do more harm than good to the child to be taken to the doctor without any illness. She also cited the example of their neighbours young son, who after getting the first injection ran fever for two days. In this case, it is clear that directing the BCC messages to the mother is not enough to change behaviours. A BCC programme needs to also identify the people who influence the behaviours of the primary intended audience, and has decision making powers. In this case the BCC programme needs to include both mothers of young children and the mothers-in-laws or husbands in its intended audience.

Identification of audience is also important for the purpose of "audience segmentation", that is classifying the larger audience into segments or groups and designing different messages for each segment, depending on their characteristics and specific behaviours. In many cases, even with the same objective

or health outcome, we will see that different segments of the audience will manifest different behaviours and therefore will need different sets of messages for change. In most cases, the audience will benefit from being segmented, and our communication activities will be more effective. Indeed, health communicators have found that to most effectively promote behavior change, they need to segment the audience and design several different customized messages, appeals, or calls to action.

> **Audience segmentation is classifying the larger audience into segments or groups and designing different messages for each segment, depending on their characteristics and specific behaviours.**

Audience segmentation is necessary for three reasons:

1. When it is useful to separate people who practice a behavior from people who do not practice the behavior.
   Example: Many BCC programmes for maternal health has identified lack of antenatal care as a key problem and pregnant women as the potential audience for a message about antenatal care. Some pregnant women may not go to a provider of antenatal care at all, while some may not start going until the second or third trimester of the pregnancy. The first groups of audience may need to understand the advantages of going to a provider of antenatal care. The second audience already understands the need for antenatal care but may need to understand the advantages of antenatal care during the first trimester.

2. When separate groups within an audience require different types of information or motivation to promote behavior change.

   Example: A potential audience for female contraceptive use may be defined as women of reproductive age. Within that group, however, young women may want two or fewer children, and modern contraceptive methods for spacing may be a solution. On the other hand, older women with three or more children may want to consider permanent contraceptive methods. Although both groups consist of married women of reproductive age, their information needs are different. However, in most cases, BCC programmes in this case have historically adopted an undifferentiated strategy, often encouraging women to choose an irreversible/permanent method that may be an inappropriate solution to their needs or may not give them a strong enough reason to seek a contraceptive method that best suits them. Segmenting the broader audience of married women of reproductive age into those who wish to space out their pregnancies and those who wish to limit the number of children that they have results in more focused and appropriate communication strategies.

3. When separate groups are likely to identify with different communicators or agents of BCC.

   Example: Many reproductive and sexual health programmes have initiated BCC to influence sexually active adolescents to practice safe sex and use contraception, and for those who are not sexually active to delay such activity. The communicators in these programmes are often adults – health workers or school teachers. However, adolescents feel uncomfortable discussing these issues with adults and may feel scared to express their doubts. They will respond to messages given by their peers rather than to messages given by adults or providers. While health providers may be effective communicators for married couples, audience segmentation in this case will help us to choose the right communicator – peer educators – for adolescents.

Note: Identification and segmentation of audience for a particular behaviour change necessitates that we are sensitive to the varying needs of different sections of the community and the different needs of groups even within the larger identified audience. Here, an in depth understanding of the determinants of behaviours can help us identify who is the primary audience, and who are the significant influencers of these behaviours. Audience characteristics are very important in designing BCC messages. Age of the audience, literacy levels, socio-economic status, geographical location, and other such demographic profiles need to be considered. A BCC programme will be effective in changing behaviours only when it identifies the right audience and designs the strategies depending on their needs and characteristics.

IDENTIFYING THE KEY MESSAGE POINTS

The next step in the BCC plan is to identify the key message points and design the message brief. This exercise will be closely dictated by not just the behaviour identified to be changed and the objectives of the programme, but also by the understanding about the determinants of the concerned behaviours and the needs and characteristics of the identified audience.

To communicate effectively with the intended audiences, the communication team needs to design messages that are (1) strategic, (2) relevant, (3) attention getting, (4) memorable, and (5) motivational. The message brief also outlines the key fact that will lead to the desired behavior change and the promise or benefit for the intended audience that ideally will motivate it to adopt the change. In summary, the message design should include the following:

Identifying the key fact: The planner for the BCC programme needs to identify a central theme for the communication strategy. In keeping with this broad theme, we will complete a message brief for each component of the strategy and will ensure that all of the messages reinforce one another. Strategic communicators and planners look for the key factor or the single most important fact in a health problem or situation that, if addressed in the communication effort, will most likely lead to the desired behavior change. The key fact may be an obstacle or an opportunity. Selection of the single most important fact is

key because a message is only effective if it addresses a single problem. The key fact can suggest the need to:

- Eliminate a problem that the audience has with the idea or desired behaviour.
- Correct an erroneous or incomplete perception that the audience may have.
- Reinforce or extend a benefit that the program delivers.
- Strengthen the reason for increasing the incidence of the practice or behaviour.
- Fill a void in knowledge or information in the audience.

Identify the benefit: The second step is to identify the benefit to the members of the intended audience that will motivate them to change their behavior. The purpose of this step is to select a promise needs to be easily understood by the audience, so that it is persuasive to the primary audience. The promise conveys the ultimate outcome that the communication programme is attempting to achieve, for example, "your children will live longer and healthier and will be stronger". The promise is the specific audience benefit that the health communicator wants the audience to associate most readily with the objective or proposed behavior change. For example, the promise of feeling secure and protected from contracting HIV or other STDs by using a condom is a clear benefit to the audience of adopting a particular behavior. Finding the promise that will resonate with the audience is one of the most challenging tasks in developing a communication strategy because it relies on having a clear understanding of the intended audience.

Defining supporting statements: It is important to define the supporting statements that summarize why the audience should believe the promise. The support statements need to be based on analysis to understand what will make the message credible to the audience. The reasons for the audience to believe the message may be factual or emotional. In the message brief, the support statements summarize why the promise is beneficial to the audience and why the promise outweighs any obstacles or barriers to adopting the behavior. **Examples of Support Statements: Factual:** Condoms prevent the transmission of disease 99.9 percent of the time. All doctors recommend their use. **Emotional:** By using condoms, you'll be less fearful of contracting a disease that will make you sterile, reduce your quality of life, or even kill you.

Describing the barriers to the message: Even if the audience understands, relates to, and is motivated by the message, there may be other factors that limit the audience's ability to adopt the proposed behavior. For example, social norms that limit a woman's ability to use family planning methods may inhibit her desire to go to a clinic and determine which method would be best for her. In many countries, HIV/AIDS is still considered a social taboo, and many at-risk individuals are intimidated from seeking testing, counseling, or treatment because they are afraid of the consequences in their communities. Most people behave the way that they do because they derive a benefit from that behavior. In the case of those who do not seek HIV/AIDS testing, counseling, or treatment, the benefit may be the protection of the individual's status and reputation within the community. It is critical to understand the reasons behind the competition when crafting new messages. Competition for the message also exists in the more traditional sense, where the message may convey information that is contradicting traditional knowledge that has historically

existed in the community. For example, from the earlier case study on malaria, the cause of malaria in the message as mosquito bites contradicts the community belief that it is caused by evil spirits.

Developing a lasting impression: The ultimate and lasting impression of the message is what people retain in their memory after seeing or hearing the full range of thoughts, feelings, and attitudes about the behavior proposed in the message. In other words, it is the "take-away" of the message, including its call to action. This has also been called the stickiness of the message. Some messages are framed in such a way that they stick to ones memory- others do not. The overall impression is not a slogan but the belief and feeling that the audience should get from the communication. The take-away message may be explicit or implicit and may be communicated verbally or nonverbally.

> **"The ultimate and lasting impression of the message is what people retain in their memory after seeing or hearing the full range of thoughts, feelings, and attitudes about the behavior proposed in the message. In other words, it is the "take-away" of the message, including its call to action."**

Describing the intended audience profile: The BCC strategy planner needs to identify the important personality characteristics that the audience associates with the change in behavior. Every message makes a statement about the kind of people that the audience perceives as performing the behavior. The planner must think like the audience and ask:

- What is the profile of someone who would adopt the behavior?
- Do others want to emulate these people?
- What is it about these people that makes others aspire to be like them or identify with them?
- Are these people perceived as aware, concerned for their families, and responsible?

Identifying key message points: Now we are ready, based on steps 1 through 6, to identify the key message points that will be included in all communication that will be delivered to the community. The key message points will be delivered in different ways based upon the tools, channels and forums that are appropriate for the audience. A message point can be a core theme, or can also be used specifically as a slogan or as a counseling message or can be built into community-based activities. All messages related to particular health objective, regardless of how they are delivered or by whom, should consistently contain the same core information. Medical personnel in health facilities, counselors, field workers, and any other partners in the communication effort should reinforce the key message points.

CASE STUDY: DESIGNING A MESSAGE FOR INCREASING USE OF CONTRACEPTION

The following table illustrates the steps involved in designing a BCC message for increasing use of contraceptive methods (both spacing and permanent) for married couples in rural Orissa:

Identify the key fact that we want our messages to address	A majority of young married couples in the area want to delay pregnancies (have more space between children), yet they are not using any contraceptive method for spacing. A lack of knowledge and limited access to services are the key problems
The promise, or the single most important benefit that we want our messages to deliver	Procedures like condoms, oral contraceptive pills, or intra-uterine devices (IUD) can protect one from pregnancies and help desired space between children
The support, or the reason to believe the promise	• Testimonies of satisfied users • Explaining how these methods work • Endorsements of health personnel
The competition for the message	• Encouragement from traditional practice to have larger families • Pressure to have a child (in case of newly married couples) • Pressure to try and produce a son (in case the first child is a daughter)
The statement or the lasting impression that the audience will have after the message	• "These methods are safe and reliable ways for me space my pregnancies" • "I am going to discuss these methods with my spouse" • "I and my spouse are going to use condoms or an IUD"
The desired user profile – how the audience perceives someone who manifests the behaviour being promoted	Happy, satisfied, healthy, sexually competent
The key message points that will be included in all communication delivered by the partners implementing the BCC plan	• The methods are safe • The methods are cheap and cost effective in the long run • Locations and times where these services are available • Description of the procedures of using condoms, OCPs and IUDs • Counteract common misconceptions about these methods, for example, condoms decrease sexual pleasure and "manhood", once using OCPs and IUDs will prevent the woman from conceiving later, etc.

CHOOSING CHANNELS AND TOOLS COMMUNICATION

A tool or channel of BCC is the way a message is disseminated. It is important to know which tools can most effectively reach particular intended populations. Identifying the range of available tools should be part of every formative BCC assessment. It is important to think about how particular tools can help achieve particular goals. Each medium has its own advantages and disadvantages, so that each may be best suited to a particular circumstance. Some of the tools that are commonly used in health programmes for BCC are as follows:

MASS MEDIA

Messages can be delivered through mass media. Television or radio spots, films and newspapers are the most commonly used mass media channels used for BCC in health. Mass media can raise awareness of specific facts, because the mass media are assumed to carry a certain authority and reliability. Mass media can also model behaviors and positive attitudes in the person of respected members of the target community. Later on in the process, however, target populations appear less interested in media authority than they are in the opinions and behaviors of people to whom they feel close. Interpersonal communication becomes primary, while the mass media play a supporting role. If mass media are used, it is important to know which radio stations and TV programs are popular with the participants. For example, it may not be cost-effective to use a less expensive local news station if the message is intended for mothers/women who primarily listen to radio soaps or music stations. Other tools that can have mass coverage are posters and banners put up in places most accessed by the intended audience.

CASE STUDY: *KAHAT HAI MITANIN:* THE USE OF RADIO IN THE MITANIN PROGRAMME

In the Mitanin Programme in Chhattisgarh, mass media was used to generate awareness in the community about the process of selecting the Mitanin, her training and her role and functions as a health volunteer in the community. A 16 episode programme called *"Kahat Hai Mitanin"* was simultaneously aired on all 6 state level radio channels twice a week for 8 weeks. Each episode was a story related to a specific theme, set in hamlet with the Mitanin as the central character. The 16 episodes were sixteen different short stories about Mitanins in different hamlets across the state. While the first four episodes introduced the programme, its objectives, and the Mitanin, the latter episodes dealt with health related themes ranging from pregnancy and antenatal care to commonly prevalent communicable diseases such as malaria and diarrhoea. The programme was in Chhattisgarhi language and also included folk songs popular among the communities. As radio was the most widely prevalent form of mass media in rural Chhattisgarh, and the programme was designed in a context specific and entertaining manner, *"Kahat Hai Mitanin"* succeeded in reaching the intended audience namely, rural communities in the state, and also became very popular, thus achieving significant awareness about the Mitanin programme.

DISCUSSION

Note how radio as the mass media tool was chosen as a channel for BCC, and the aim that the programme sought to achieve – generating awareness and sensitising communities to health related issues and the new health worker.

Also, note how the programme was designed in an entertaining and context specific way to attract the intended audience, rather than as didactic messages and information being given by an 'expert'. This is important for the audience to identify with the programme and accept information that it is disseminating.

Can you think of other health programmes that have used mass media successfully? What were the characteristics of the mass media tool chosen or the campaign/programme design that contributed to this success?

INTERPERSONAL COUNSELLING BY LOCAL WORKERS

In largely resource poor settings, in rural contexts where access to mass media is limited and rates of literacy are low, BCC messages can be communicated in-person, by health workers, peer educators, or other trained personnel. Health workers can help reach specific groups, model desired behaviors, stimulate community discussions and provide referrals to health services. In many contexts training local individuals, in most cases women, as agents of BCC and health and nutrition educators has been shown to yield significant impact. The advantages of this strategy are manifold – these local workers are familiar with and sensitive to the contextual realities and can therefore, impart culturally appropriate messages. Besides, the participants can identify with these local workers more than they can with healthcare professionals in health facilities. The local workers are present in the community, and are not subject to transfers and changes on the basis of human resource policies of the health system. The sense of permanency and rapport with the community increases the probability of affecting sustainable behaviour change.

CASE STUDY: COMMUNITY HEALTH WORKERS IN RURAL WEST BENGAL

Interpersonal counselling by local workers as a channel for BCC has been used by the Child In Need Institute (CINI) in rural West Bengal. The locally selected community health workers in rural areas act as the agents of BCC, providing knowledge about child health and nutrition, counselling mothers and families, involving the husbands and the mothers-in-law in such sessions for sensitisation and support to the desired health behaviours. Done through home visits and counselling, the health workers not only provide essential information, but also guide the families to allocate resources to nutritious food, encourage early initiation and exclusive breastfeeding by the mother and adequate complementary feeding, motivate families for immunisation and seek regular health care for their children. Evaluation of the interventions show a decrease by one third in low birth weight, malnutrition and childhood stunting, as well as a significant rise in healthcare seeking behaviour and in rates of immunisation for children.

DISCUSSION

Can you think of some other health programmes that have used interpersonal counselling for BCC in communities? Who were the agents in these programmes? How are they different from local workers? In which contexts, and undertaken by which agents do you think is interpersonal counselling effective in changing behaviours?

FOLK MEDIA

In rural communities where various forms of folk media such as songs and stories in local dialects, dances and theatre are popular means of entertainment, BCC can be delivered through such tools. Musical or dramatic performances and community events can deliver messages and influence behaviours in a culturally relevant and acceptable manner.

CASE STUDY: *KALAJATHA* – THE USE OF FOLK MEDIA IN THE MITANIN PROGRAMME

In Korba district of Chhattisgarh, kalajathas were used as channels for generating awareness and dispelling myths and superstitions in the communities. A total of 8 kalajathas toured the four blocks of the district , giving over 480 performances in all. The usual kalajatha programme in a village is usually about two hours long with two or three short plays, each about half an hour long interspersed with about six or seven songs, all of them sung as a group with some minimum choreography that relates to the meaning of the song. And the entire two to three hour programme is interspersed with a number of short speeches introducing various health issues or information on the programme. The plays are a mix of folk theatre and street theatre styles, drawing on folk forms but not being bound by them. The construction of the plays takes a lot of effort as it goes through a stage of writing scripts and then of developing them into a production. Then a theatre director and a music- master are trained in the package of plays and songs. These programmes are then performed by a local block or district level theatre group many of whom are first time participants. This group travels from village to village in a 15 to 30 day campaign giving two to three performances per day and thus systematically covering a wide number of villages. Preparatory work in each village ensures that there is an audience drawn from all neighboring villages and hamlets. The kalajatha format of communication was first used in a major way in India to generate enthusiasm for the literacy campaigns in the early nineties and to generate a large number of volunteers for the campaign. In the Mitanin programme the kalajatha was used to introduce the role and functions of the Mitanins to the community. Kalajathas were prepared around health related themes and common superstitions such as food taboos and practices during pregnancy, seeking healthcare for common illnesses and for pregnant women, causes attributed to certain illnesses, and child caring practices. The dramatisation of common situations and their presentation in a humorous and entertaining manner make these kalajathas very popular, generated awareness about health issues, and helped to address certain behaviours and some prevalent superstitious beliefs.

DISCUSSION

What kind of issues do you think can be successfully addressed by folk media as a channel for BCC? Can you think of any other health programmes that have used folk media?

In resource-constrained settings, it is especially important to look for opportunities to link various channels taking advantage of a maximum number of opportunities. Message design cuts across all communicatio channels, such as Inter-personal communication (IPC), community based activities, and mass media The more the messages reinforce each other across channels, the higher is the probability of effectiv impact. Strategic health communicators craft key message points that are consistent and relevant for a channels and tools. This consistency and relevance contribute to the overall effectiveness of th communication strategy by ensuring that, for example, the service provider, the community mobilize and the actor featured in a radio announcement all reinforce the same key message points. This approac does not mean that planners create only one message for all these venues. It does mean that the identify the key points that are to be made in every message that is communicated to the audience, n matter which channel or tool is used.

> **"In resource-constrained settings, it is especially important to look for opportunities to link various channels, taking advantage of a maximum number of opportunities. The more the messages reinforce each other across channels, the higher is the probability of effective impact."**

The following table compares the advantages and disadvantages of these BCC tools:

BCC Channel	Specific Tools	Advantages	Disadvantages
Mass Media	Television	• Is relevant for both literate and illiterate groups • Reach can be broad • Cost per person reached can be low • Is a strong medium as it combines visual dimension with spoken word • Can influence behaviours that are not deeply entrenched • Message can be adequately controlled and there is no loss in transmission. • Helps create favourable environment that facilitates other interpersonal communication efforts.	• Television ownership often mainly with high income urban population • High initial investment in production • Difficult to meet needs of specific groups • Lack of feedback. • High cost of production and not easy to make changes once production is complete.

BCC Channel	Specific Tools	Advantages	Disadvantages
	Radio	• Very broad reach • regional radio provides opportunity to broadcast in local languages • Easy to include content from interviews/music from local communities • simple and more affordable to make programmes • Can record programs on cassettes and play to local audiences • Is effective with both literate and illiterate populations • Is owned by poor rural populations. • Creates a favourable environment that would be supportive of interpersonal communication.	• Lacks a visual dimension • depends on appropriate timing of broadcasts, quality of reception, and availability of electricity or batteries in rural areas • lack of feedback and interaction with the audience- though this can be ameliorated to some extent by feed-back postcards and some airtime given to feedback communication.
	Newspapers	• Reach can be broad • Can provide specific information	• Is relevant only in literate populations • Coverage in interior rural areas is absent
	Posters	• Serves as constant reminders of a key message. • Can be distributed to highly targeted groups • Can be pictorial to suit non-literate populations • Can provide specific information/messages • Can be easily designed without incurring high costs	• Cannot influence entrenched behaviours- more of a support to other activties • Place of display needs to be strategic and well planned. Massing posters in a key point creates one sort of effect. Posting posters all over a village creates another.

BCC Channel	Specific Tools	Advantages	Disadvantages
Interpersonal	Community Health Workers	• Takes information out to where the community live and is effective for difficult to reach populations • The audience can easily identify with them, when selected from the community • Allows the messages to be made specific to the needs of the audience, taking into account their special needs and contexts • Can be very effective in changing even highly entrenched beliefs and attitudes • Can act as community mobilizers and work towards empowerment • Audience can be a participant in a dialogue instead of being a mere passive recipient.	• Is time, effort and resource intensive • Training needs to be of high quality, with adequate support structures and supervision • Needs to be sensitively selected and accepted by the community • Can be loss of information in transmission • Needs facilitation at community level – especially for entrenched behaviours which are the current community norm.
Interpersonal	Peer Educators	• Similar advantages as community health workers • Can be very effective for specific age groups, such as adolescents, as they can identify with peers more than with health workers of older age groups	• Similar disadvantages as community health workers
	Medical Personnel	• Has technical knowledge • Can have high credibility to the audience	• Availability is not sufficient, especially in rural areas • Messages can become highly medicalised • Difficult for populations to identify with • Relationship with audience can become hierarchical

BCC Channel	Specific Tools	Advantages	Disadvantages
Folk Media	Theatre, songs, dances	• Is culturally relevant and can therefore be very effective questioning attitudes and mindsets • Can change highly entrenched behaviours and attitudes • Is entertaining, and therefore can engage people while using humor to question mind-sets • Is simple to produce with low costs • Much greater penetration to reach the entire community especially the weaker sections. • Is more interactive and participatory than mass media • As they are locally prepared, they can reach difficult groups • Is relevant for both literate and illiterate populations	• Supervision is required in preparing the content/script • Not suitable for technical information • Close follow up is necessary

FORUMS FOR BCC

As is clear from the previous sections, determinants of behaviour are multifactorial and interventions need to be at different levels in order to bring about behaviour change. In this section we will discuss the different forums in the community where BCC initiatives can be undertaken in effective ways. It is important to remember here that like in the case of tools, different forums are useful for addressing different behaviours, involving different audience segments, and using different tools. The choice of the platform or the context in which the intervention is initiated is affected by the focus of the programme, the intended audience, the analysis of the determinants of maternal health behaviours by the programme, as well as challenges and opportunities presented by the context in which the programme is introduced. Besides these, the contextual realities of the community such as social divisions, geographical distance language and power structures determine the feasibility of one forum versus the other. Some of the forums commonly used for BCC interventions are interpersonal one-to-one communication with individual members of the intended audience, with family members of these individuals through communication at the household level, groups and committees formed as a part of the intervention, existing community based structures for integrating the interventions and reaching to the larger community than restricting the focus to one target group.

Some of these forums are described below:

INDIVIDUALS

The interpersonal level is the most fundamental level of health-related communication or BCC interventions because individual behavior affects health status. Communication can affect individuals' awareness, knowledge, attitudes, self efficacy, skills, and commitment to behavior change. Activities directed at intended participants for change can affect individual change.

CASE STUDY: ENSURING COMPLIANCE TO DOTS FOR TB CONTROL

Addressing compliance behaviour for the DOTS (Directly Observed Treatment, Short Course) programme to control tuberculosis is an example of working with concerned individuals to bring about behaviour change. Under the Revised National Tuberculosis Control Programme (1997) the DOTS provider, a local health worker, is involved in concentrated case management of each TB patient, starting from detection by sputum smear microscopy examination among symptomatic patients, ensuring that each patient takes the TB drugs under the direct observation of the DOTS provider, and by systematic recording of the treatment results of each patient for assessment and follow up.

This concentrated case management of each individual patient by the DOTS provider is mainly to ensure his/her compliance to the therapy regimen, and thereby preventing any individual from dropping out from the programme without completing the entire course.

DISCUSSION

Do you think the BCC at the level of the individual is an effective and feasible strategy? Which are some of the health related behaviours that you think need to be changed through such concentrated individualised strategies?

FOCUSING ON FAMILIES

In most cases, the concerned individual cannot be isolated from the context of the family or the household. Working with families or households as a unit is therefore, important to change perceptions and attitudes about health and create an enabling environment for the individual to translate his/her knowledge about appropriate health related behaviours into practice. Besides this, most health issues affect ,and are affected by, the family as a whole, and therefore, BCC interventions need to involve all the members, rather than selecting an individual. Working with the family becomes more important in case of behaviours related to child care. In this area, although the mother is the primary caregiver, more often than not she

has limited decision making powers and control over resources within the household. At times, a narrow focus on the mother may not result in changed behaviours, and may get reduced to "blaming" her for all that has gone wrong with the child. It is therefore, imperative that her husband and her mother-in-law are also involved in the BCC initiatives.

CASE STUDY: SEXUALLY TRANSMITTED INFECTIONS – THE NEED TO INVOLVE BOTH PARTNERS

In Hazaribaag block of Jharkhand an NGO initiated a BCC programme regarding women's reproductive and sexual health. Following the awareness and information, a number of women came to the PHC for check-ups and were diagnosed with sexually transmitted diseases (STIs). The doctor in the centre gave them appropriate medicines for their infections and reiterated the messages given in the BCC programme about using condoms to prevent such transmissions. However, a majority of the cases suffered from relapse, and came back to the doctor for treatment. An analysis of the reasons behind this phenomenon was that although the women completed the full course of the medicines, they could not ensure that their husbands used condoms during sexual intercourse. Most of the time the women would be too shy to make this request, and in cases that they did, the husband would often refuse to use a condom arguing that it is not necessary or that it reduces his sexual pleasure.

It is clear that for changing behaviours effectively and reducing rates of STI, the BCC programme needs to involve the men.

DISCUSSION

Clearly, both in case of reproductive health and child health related BCC programmes, the forums need to involve the couple or the family as a unit. What are some of the other behaviours where the family as a forum is crucial to bring about effective change? Can you think about any national or state based campaign that has focused on the family as a unit for behaviour change?

KEY ADVANTAGE OF INTER-PERSONAL COMMUNICATION

The advantage of interpersonal communication as a BCC strategy is that it permits dialogue with the individual and the family on their perceptions of the need for change, helps clarify the specific set of information gaps, and explores together what is feasible in a specific context. It is in this form more than any other that the recipient of the message can be a participant- if the communicator provides such a space. In this understanding the recipient of the information is a conscious rational person who faces barriers to making a change – whom the communicator helps, supports, facilitates in making the changes she needs. That is why members chosen from the community and trained are likely to be more effective since they would have to dialogue, not impose ideas, and would have to negotiate change. That is – if the

communicator is from the same caste and class strata. If not, even at this level – health messages can become an imposition and a prescription, instead of being a dialogue.

> **That is why members chosen from the community and trained are likely to be more effective in achieving behaviour change since they would have to dialogue, not impose ideas, and would have to negotiate change.**

This advantage is also present when the dialogue is with a group in the form of a focal group discussion. Indeed because of synergism the effect could be even more pronounced. This is discussed below.

INTERVENTIONS WITH GROUPS

Informal groups to which individuals belong, as well as groups of individual members of the intended audience have been used to initiate BCC activities. The similarity of situations experienced by the individual members of the group helps them to identify with each other and create a social support structure that is imperative for sustainable behaviour change. In most cases, the group that is formed as a platform for BCC themselves become an intervention. The synergistic mode prevalent in a group situation facilitates the group to create knowledge from which actions can be agreed upon and taken by the members. Some experiences have also shown that when small groups learn about new concepts they provide a catalyst for community learning and transformative change because numbers of individuals share a knowledge base that they may infuse into environments outside the learning group, creating the possibility for greater community learning.

CASE STUDY: FORMING MOTHERS' GROUPS FOR CHANGING CHILD CARE PRACTICES

An NGO in Chakradhapur in Jharkhand has formed mothers' groups for initiating BCC related to child caring practices. A female facilitator convened nine mothers' group meetings every month. The facilitator supported groups through an action-learning cycle in which they identified local pregnancy related problems and formulated strategies to address them. Discussion of these maternal and child health issues by these groups in a focused way helped generate awareness about the need for health care seeking for these issues. Observation has also shown that uptake of antenatal and delivery services, child feeding and caring practices, immunisation and health seeking for childhood illnesses have steadily improved in the community.

DISCUSSION

In these interventions through specific groups, the impact of the BCC in terms of diffusion and multiplicity of effect and in sustainability of the changed behaviours, can be significant. In certain cases the groups that are formed especially for introducing BCC, can act as interventions in themselves. The groups are support structures for the individuals as they inculcate a sense of belongingness, a purpose towards achieving the same goals, and an increased sense of social capital and efficacy of the collective to change traditional perceptions and behaviours related to health, even in the possible opposition from other members of the community.

INTEGRATION WITH COMMUNITY BASED STRUCTURES

The significance of working with communities to change health outcomes cannot be undermined. Programmatic experiences emphasise the role and effectiveness of communication based interventions with communities and community based structures to change health behaviours. Communities not only influence health behaviours on the basis of prevalent socio-cultural beliefs and practices among them, but also by creating an environment that can enable individuals to practice appropriate behaviours. Programmes have introduced communication based interventions at the community level through pre existing community based structures such as Gram Panchayats, Village Health Committees, Mahila Mandals, Yuva Mandals, Farmers' Clubs, and self help groups. As these structures are pre existing, the members share cohesiveness, and a background of social mobilisation that can facilitate the process of behaviour change for health.

CASE STUDY: VILLAGE HEALTH COMMITTEES IN JHARKHAND

In rural Jharkhand, village health committees (VHCs) at the village level, comprising of representatives from the community have proved to be effective forums for initiating BCC activities. The Sahiyyas (community health workers) undertake sessions on health related topics with the VHC twice a month. Ranging from generating awareness about maternal and child health and nutrition to hygiene and sanitation in the village, the BCC activities aim to disseminate information, change behaviours of the VHC members, and encourage them to undertake pro-active action related to these issues. The VHCs, in turn have disseminated this awareness to the larger community, and have initiated activities such as cleaning public places, chlorination of water sources, raising alert about disease outbreaks in the village, as well as collecting and maintaining a small fund for use in case of health emergencies.

DISCUSSION

Do you think existing community based structures are good BCC forums? In what contexts, and for what behaviours can they be most effective? Do you think there are certain characteristics of these structures that may either facilitate or impede BCC initiatives?

INTERVENTIONS WITH THE LARGER COMMUNITY

Society as a whole influences individual behavior by affecting norms and values, attitudes and opinions, laws and policies, and by creating physical, economic, cultural, and information environments. BCC programs aimed at the societal level can change individual attitudes or behavior and thus change social norms. Very large scale, statewide interventions have focused on the entire community as a platform to initiate BCC, although in most cases such an approach supplements more specific interventions, such as counselling of individuals or formation of groups.

CASE STUDY: VALUING THE GIRL CHILD

The nationwide campaign initiated by different NGOs, funding agencies, women's groups and governments to change societal values of discriminating against the girl child is an example of a BCC programme aimed at the larger society. The campaign has used channels like TV, radio, short films, newspapers and posters displayed at health facilities, schools and public places to change practices that discriminate against the girls and women. The campaign includes messages condemning crimes against girls and women like sex selective abortion, female foeticide, female infanticide, domestic violence and dowry related violence; and encourages people to value their daughters, giving them equal opportunities as their sons in terms of education and employment.

DISCUSSION

What are some of the behaviors that you think can be changed by addressing the larger society? Do you think other BCC through other channels and forums need to accompany this strategy? If yes, then what could be some such channels and forums in relation to the case study above?

Review Questions

1. What are the steps in developing key message points on a topic?.
2. What are the advantages of electronic mass media and what are the disadvantages.
3. What do we understand by the term audience segmentation?
4. Describe the kalajatha. How does in differ from other uses of folk media.
5. What are the advantages of inter-personal communication to individuals, to families and with groups? How do we create a facilitatory environoment that enable effectiveness of IPC.

Application Questions

1. Look at the use of hoardings and posters in the district BCC campaign? Whom did the message reach? What effect would it have had on them? How much would have been the expenditure on them?
2. Listen to the Kalyani serial on television. This has been one of the more successful efforts at television based communication. Find out what audience segement it reaches. What of the principles of BCC do we find incorporated in that episode? Would you have like to structure the episode differently or bring a different focus to the message, knowing the audience segement?

Project Assignment

1. Decide on the key behaviour changes sought in:
   RCH
   Any one disease control programme in your district?
2. Do a brief study to understand the current behaviour and its determinants. It may be just one focused group discussion or a 50 household village sample survey or both. On this basis decide the following for the district plan:
   Identification and segmentation of audience
   Developing key message points
   Tools and channels for BCC
   Forums for undertaking the BCC activities with the intended audience

NOTES

Lesson FOUR

The Situation in Training

In this lesson we shall discuss:

- The level and nature of trainings achieved at the district level
- The quality of training issues
- The state of training institutions – in service and pre-service
- The importance of incorporating a training strategy and a training plan in the district plan

INTRODUCTION

Comment overheard of a district collector:

"Training... Training... Training.. Does anything come out of training? Whenever you ask where a particular staff member is, they tell you he has gone for training. But nothing much changes in the service delivery. They just get time to get away from the village. When motivation is so low, what difference can training make? Let me tell you what we need is strict monitoring".

Such views are common and by no means confined to only District Collectors. Even Medical Officers make this comment in such a manner quite often.

While discussing training we need to understand:

- What is the exact situation with training? Is it that everyone has had training?
- Is it true that training makes no difference to service delivery because the other factors like motivation are more limiting factors? Or is it that the training has been so ineffective that it actually equals to no training.
- How much training does one need anyway? And how does one make it effective? How does training relate to service delivery?

TRAINING : A SITUATIONAL ANALYSIS

a) Training received by health workers – in terms of days

How many workers are trained? And how much training have each received? An SHRC study of the level of training in a district showed data displayed in the table below:

TABLE 4.1. TRAINING OF MPWS

Item	% of MPW(F)s interviewed	% of MPW (M) interviewed
MPWs who received no training at all in last 3.5 yrs	48.39	68.66
Who received no training more than three days in last 3.5 yrs.	86.02	17.91
No training at all	7.53	77.61

Source: Primary data from O&M Survey of MPWs

But these trainings had not been evenly distributed amongst the ANMs. A few ANMs had received five trainings in one case within two years while many had received no training at all. The table below gives us an idea of the variance in this aspect. This skew is even more obvious in MPW (M) where 77.61% of them had received no training in last 15 years and sometimes had never , ever received training.

b) Training received by Health workers – by topics

If we look at what training was received, we find some common pattern in the MPW (F) where most female workers had received a 12 day course in RCH but none at all in MPW (M) where the pattern is completely random. Even in female workers- other than on RCH the pattern is haphazard.

TABLE 4.2 TOTAL TRAININGS RECEIVED IN 93 MPW (F) INTERVIEWED

	Number of MPW (F) trainings since 2000	*Number of MPW (F) trainings in 1994 - 2000*
RCH	19	70
IPP-6	3	26
TB	15	-
Leprosy	13	-
Malaria	5	3
Polio	5	1
Mitanin	4	-

Source: Primary data O&M survey MPW(F).

Training in MPW(M)

	Number of MPW(M) trained since 2000	Number of MPW(M) trained in 1994 - 2000
Microscopy	5	1
Malaria	5	-
Leprosy	10	1
RCH/CSSM	3	33
TB	13	-
IPP	3	16
Pulse Polio	3	-
School health	2	16
Mitanin	1	-
Paramedical?	2	-
ECG/ICCU	1	-

This training pattern is grossly inadequate- for both male and female workers. The above tables show almost a random pattern of training for male workers and one training on RCH skills for ANMs other than which all other trainings are quite haphazard in choice.

There are no regular refresher courses. Considering their range of activities, the training given is very limited. There are many tasks – like curative care for which they get no inputs at all. These need to be revived through training.

Aspects like social mobilisation, community participation, village level action planning, communication skills, IEC etc. also need systematic training inputs. Frequently changing national programme guidelines also make frequent reorientation necessary. Obviously this has not been happening.

One specific concern about lack of training in the male worker is that most of them did not have the basic 18-month training course that is mandatory for recruiting a female worker. Many male workers had joined as smallpox vaccinators, malaria workers etc and when these cadre was merged to constitute the MPW (M) cadre they received one month training or none at all.

c) Training of Supervisors

This is even truer of male supervisors for this cadre – where the majority of them did not join as multi-purpose workers but were subsequently absorbed in this category during the policy shifts when uni-purpose workers of different programmes were made multi-purpose workers. When a female MPW is promoted to a supervisor it is mandatory for her to undergo a six month training programme. This used to lead to reasonably good quality LHVs. Now this process is often either not continuing or with lesser degree of seriousness to it. In contrast when male MPWs are promoted to supervisors there is no training planned at all.

As a result of these factors, knowledge and skill levels of supervisors can be very low. Thus the supervisors of the workers are much less trained and have less knowledge and skills than those they supervise. This rules out any possibility of supportive supervision or on the job trainings altogether.

d) Training Needs by Facility

If, after all this training, we examine each facility for whether the skills needed for all the services to be delivered there are in place – the study found major gaps.

Thus in one block out of 27 sub-centres and 3 PHCs only 10 were performing IUD insertion. On closer inquiry it was not a motivation issue – the remaining ANMs just did not know how to insert IUD. Similarly when examined for how many ANMs could manage birth asphyxia or recognise neonatal sepsis the numbers are very low. It was even lower for male workers.

e) Training for medical officers

This is the same situation in the training of doctors too – only the crisis is much greater. The requirement for doctors to keep abreast of developments, to learn new clinical skills and to learn management and administration and public health is enormous. But we have the same pattern of sporadic trainings and haphazardly selected trainees. Firstly, we find a number of doctors do not have the knowledge and skills needed for their roles – as health administrators, as public health functionaries and even as clinicians. Secondly, if we look at a facility it is not the number of doctors that is critical, once at least four doctors are available – it is the number of skill sets available. Thus if there are four or six doctors and none of them can mange a complication at delivery or take care of a sick neonate- this would be difficult.

EXPLAINING THE TRAINING GAPS

Why does the situation mentioned above occur? How are the training programmes decided? How are the trainees decided?

Decision on choice of topic is usually fund driven. Usually the funds for training come along with one or other centrally sponsored programmes and this fund needs to be expended. For example, there may be a training component of the tuberculosis programme, and sometimes it may be a training component of the HIV control programme and often it is the training funds of the RCH programme.

> **"Decision on choice of topic is usually fund driven. Usually the funds for training came along with one or other centrally sponsored programmes and this fund needs to be expended."**

Decision on choice of trainees tends to be arbitrary. The programmes would specify the number of people to be trained and how many would be trained - with each district allotted a quota of trainees. Some trainees would be keen to go for the training programme and some would be able to corner many of the opportunities – while others would get none.

Indeed it is difficult to make any non-arbitrary choice. No roster exists in any of the EAG states which indicates what skills exist in each facility and what each employee has been trained for . Not even records of past training plans and choice of trainees is available.

No wonder the comment is made that a lot of training happens – but with no improvements in service delivery.

Further there are almost no provisions or plans for on the job training.

QUALITY OF TRAINING ISSUES

CASE STUDY

A three day training programme was announced. Seventy trainees were invited. On the first day there was an inauguration that got delayed as the chief guest came late. After that was lunch. It took quite some time to complete and get reassembled.

Then certain key officers had to be called since it was important to involve them. Each of them were given a topic to speak on. In the last half hour the trainer who had been trained at the state level introduced the training material and asked them to read it and come. By then some of the people who had to go back to homes or for other work had left.

The next day training was to start at 9.30 a.m. but it was 11.00 a.m. by the time and 12.00 noon by the time there was full attendance. For each session a senior persons had been called as a resource person. The first of these just kept the training guide aside and gave such an impressive talk that everyone was impressed. It was quite humorous also and it kept everyone's attention.

In contrast the second person followed the training book mechanically and his talk was very boring. Few paid attention.

For each day three resource persons had been fixed. They came, spoke, and left. The trainer who had taken training at the state level attended on all days- but did not take any session as he was too busy with the organisation. On the last day there was a valedictory session that the collector attended. When asked to comment on the training programme by the collector, most of the trainees said quite enthusiastically that they had found it useful. Amongst themselves they agreed that it had been a waste.

DISCUSSION

There are over a dozen errors that one can count in the above case study – things that should not be done in that way. And things like training evaluation that should have been there but were not there. As an exercise list them.

Many, if not most, training programmes are designed very weakly. Many training programmes are completed without having the training materials fully developed.

Here is a list of some of the common errors in the training camp – many of which are seen in the example above:

1. There are too many trainees in a single batch. It becomes more of a conference. A batch of seventy trainees, for example, is too big for a training session. One cannot even establish eye contact with all participants. Thirty to forty is the maximum even for a large scale programme. Many trainers would like to work with only twenty trainees.
2. Too much time is lost on inauguration and valedictory – the training session becoming an occasion to satisfy senior officers or ministers rather than keep the focus on building competencies.
3. Poorly organised breaks for lunch and tea can rob a lot of training time.
4. The trainer becomes decided by all who have to be given a share of the stage and speaking time. Because they are senior it is assumed that they can train better. The focus on building competencies is lost. The programme becomes boring and loses its participants.
5. Training sessions are often conducted by those who have not been trained as trainers.
6. The training programme is broken into sessions – but there is need for coordination to see that the content is being well covered. Wherever there are gaps in a particular session – these need to be filled up in subsequent session. If each trainer comes and goes – they have little knowledge of what happened before and after- and though they may have done their bit the entire programme does not add up to yield the desired outcomes. Coordination of the academic content of the programme is essential but usually coordinators are so bogged down with logistics and VIP movement that they are not able to focus on content.
7. Impressive speakers with good oratory skills are not necessarily good trainers. The issue is whether they are able to adequately build competencies. And not only feedback but formal training evaluation is needed to assess this.
8. Poor speakers with poor articulation also fail to convey adequate information or build competencies. Training is a skill and though it can be built up in most - not everyone has it as of then.
9. Only lectures is a boring and ineffective way of imparting training. Other methods like group discussion, field trips, role plays, group work etc. are essential.
10. Systematic use of training material is essential to ensure that all aspects of training are covered. In the absence of such training material – content would invariably get lost.
11. Training evaluation is essential in a good training. In its absence we do not know whether the training was effective. Ineffective training is a sheer waste of time and resources – and such ineffective training which has not been evaluated is all too common.

We are now becoming sympathetic of the view expressed in the first paragraph!!! If this is the quality of training then obviously training would be perceived as an useless activity by the administration and by other decision makers.

TRAINING INSTITUTIONAL STRUCTURES

Since the training load is large and training is on technical domains there is a need for a district level institutional structure supported by a state level institutional structure.

Most states have a State Institute of Health and Family Welfare or equivalent which is charged with the task of in-service training. In some states they are functioning well. In many states there are large staffing gaps and only one or two senior persons are managing the situation. And further these institutions have become stand alone institutions implementing some of the training programmes decided at the national centre – with little involvement in planning to meet the training needs of the state or role in supervision and guidance to the district training centres.

Similarly there was a time when the district training centres were built with much expectations. However the post of the district training officer was not attractive, career wise- and many officers with poor interest levels and skills would be posted there. The total complement of staff needed were seldom put in place. Also the buildings were quite often put to other administrative uses and training programmes seldom happened there. But perhaps what was most fundamentally missing was that the district training centres did not maintain any record of what training each employee had received and of what skills each facility was lacking in- and hence could never propose or make any district level plan. It would only implement in knee-jerk fashion any training programme that came its way from one or other national health programme.

PRE-SERVICE TRAINING ISSUES

Pre-service training refers to a training programme before persons are recruited into service. This is a strange term – for is not all medical and paramedical education precisely this? This is therefore, better discussed along with medical education.

However, there were some categories of training where the only source of training was the government training institution and where the only employer of such training was the government health system. Today this is still largely true of training for multi-purpose workers (male) and multipurpose workers (female) – otherwise known as ANMs. A related training is the six month training that ANMs have to mandatorily receive before they are selected for promotion to the post of health supervisor (female) or as called earlier Lady Health Visitor (LHV).

For rather inexplicable reasons these ANM training centres and LHV training centres all fell into disuse in the nineties – leaving a huge gap in the generation of suitable candidates for this cadre. This is even more of a problem for male health workers. Since jobs are almost certainly guaranteed there is considerable demand for this course.

These courses were meant to be a vocational stream of the +2 stage – higher secondary stage and linked to the higher secondary examination as well – a position that the nursing council continues to uphold – but is often lost during implementation.

These courses are to be recognised by the nursing council.

Today the picture is somewhat complicated by the private sector also being allowed to run such courses. Thus in the state of Andhra Pradesh more than 140 ANM training schools have opened up and there is no system in place of ensuring quality standards. In most states these courses are run only by the government though public private partnerships are being sought for this.

Reviving and re-positioning of the MPW training schools are one of the important elements of the health sector reform programme. Planned carefully we can ensure that local girls from tribal areas and remote areas are able to access such training and qualify to go back and serve their villages. Many of them may be later retrained to become nurses and even doctors. But allowed to proceed in an ad hoc manner we would again have a number of urban women who gain access to this training and continue to seek postings in urban areas or shuttle from urban areas – leaving the rural areas still under-serviced – while creating frustration and underemployment among the educated.

The quality of training in these institutions must also come under much better scrutiny and efforts at improvement. With the proposed expansion of the ANM staff strength under NRHM there is special urgency to the task of expanding pre-service training facilities under NRHM and improving their quality and making recruitment of candidates appropriate to the needs of the public health system.

These issues would be discussed further along with the module on health sector reform.

In summary:

1. Though frequent training programmes are being conducted, most of the staff have not been trained in recent years.
2. The training plan is not driven by the central goal of ensuring that every facility has the desired set of skills it needs to deliver the services. Training programmes are more based on funds made available under national programmes. Most consist of short one or two day sensitisation programmes on different national programmes.
3. Also as a result of such a lack of training plan certain categories of staff receive little training and within categories some receive repeated training while many others may never attend any training programme over decades. There are very limited continued medical education opportunities for medical officers and very little access to upgrading skills in areas of their choice.

4. Supervisors have to provide in support - technical support and, on the job training to those whom they supervise. However many of them are less exposed to any training programmes than those whom they supervise. Their lack of training is more of a problem because pre-selection qualification for appointment to supervisors had not been insisted on, when many categories of staff were absorbed as supervisors.
5. The medical officers role as team leader, which includes providing technical supervision, and on the job training for his team has not been appreciated at all.
6. Skill upgradation to close specialist gaps had not been envisaged. This issue has become critical in view of specialist gaps being not planned for.
7. Above all, quality of training programmes remains very poor and no system of training evaluation is in place.
8. Training institutions are understaffed, and not providing leadership for the training process. Many of them are in disarray.

NEED FOR DECENTRALISED TRAINING PLANS

However all these gaps do not diminish the importance of training. *Training is the single most important input in any process to improve the quality of health services.*

Whenever new staff joins, training is essential to make them function within the system. Every year new strategies and programmes are introduced or changes are introduced and these need to start up with training programmes. Even existing programmes need retraining of staff to keep them updated.

Besides training the health employee, the training infrastructure is also used for training community health workers, advocacy with stakeholders, and capacity building of other stakeholders like Panchayati Raj institutions.

Clearly, what is needed is not less training but a well thought out training plan which is followed with adequate quality. Training plans made at the state and national levels are not able to adjudge district priorities and possibilities. The training plan has to be made at the district level – and aggregated if it is to address the actual needs.

“Training plans made at the state and national levels are not able to adjudge district priorities and possibilities. The training plan has to be made at the district level- and aggregated; if it is to address the actual needs.”

Review Questions

1. Is there cynicism about training in your district? What could be the reasons for this?
2. What are the common problems with the way trainees are decided?
3. What are the reasons for poor quality of training programmes?
4. What are the institutions of training at the district level?
5. What is the difference between pre-service training and in-service training?

Application Questions

1. District Training Centres were built up in most districts in the eighties. In the nineties most of them went into disuse. Is that a correct statement with respect to your state? What could be the reasons for their poor state of health now.
2. What have been the experiences and problems of organising continuing medical education programmes.

Project Assignment

1. Take the IPHS list of services for a sub-center, for a PHC and for a CHC. Choose three samples from each of these facilities. Choose them purposively so that they have adequate staff- in numbers. Then meet each one of them and find out that between all of them taken together what are the skill sets available to deliver the list of services they are intended to deliver and what are the skill –sets that are not available. Categorise them into two groups- skills sets that are not available in any of the facilities of that level which were sampled. And secondly those that were available in some facilities but not in all.
2. If there is a district training centre, visit it, find out what it is used for , how many trainings happen and who are the staff there.

NOTES

Lesson FIVE

Training in a District Level Health Plan

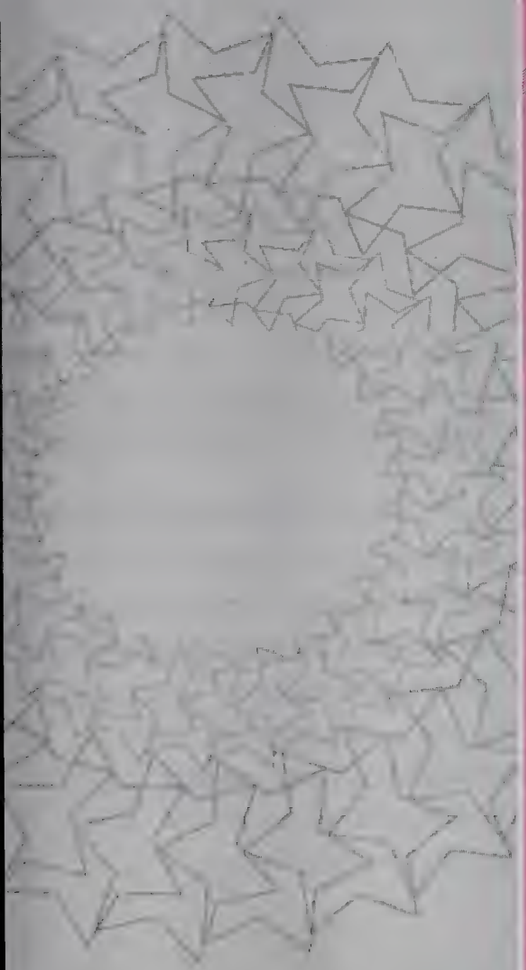
In this lesson we shall discuss:

- All the elements of a district level training strategy for the public health system

  a. Training requirements

  b. Training strategies for each category

  c. State level inputs needed to support such a plan



THE "STANDARD" DISTRICT

What are the training requirements in the usual district?

For the purpose of discussion let us agree on a "standard" district. Such a district has the following features:

- It has a population of 10 lakhs (1 million people) according to the 2001 census.
- It has 10 blocks each of which has 1 lakh population.
- It has 1 district hospital and 10 CHCs - 1 CHC per block
- It has 1 civil hospital in 1 of the blocks.
- It has exactly 3 PHCs in each block and 25 sub-centres.
- It is a tribal district.

If within a standard district, we consider a standard block with the following features:

- It has sanctioned 1 ANM per sub-center, and all posts are filled.
- It has sanctioned 1 MPW per sub-center, but only 15 out of 25 posts filled per standard block.
- It has 4 male and 4 female supervisors per block sanctioned and filled.

The standard block has a compounder, laboratory assistants and a dresser sanctioned per PHC, though on an average only one of these 3 posts are filled. Thus against 9 such posts in every block only three are filled. Their work is to support the doctor in the PHC, and if the doctor does not come they have not much to do. If the doctor comes they still do not have much to do because without the other two, the support is not complete.

It has also three other workers – two from the leprosy programme and one a former malaria inspector post whose current job description is vague.

At the block CHC there are 4 nurses, one person called a computer (he pre-dates the discovery of computers and is actually a person concerned with computing statistics which too he seldom does), a block extension educator and two clerks. A ward-boy looks after the accounts. The others are a driver, an X-ray technician and two laboratory technicians.

In medical staff we shall assume that the standard block has 6 doctors against 9 sanctioned posts - four in the CHC against six sanctioned; and two in the PHCs as against three sanctioned posts. At the district hospital there are 15 doctors against 20 posts and 5 of them specialists and 10 nurses other than another 15 technical support staff. **Thus about 35 doctors posts are vacant and at least 20 of them are likely to be filled up this year.**

There is also the staff of the district training center, and many supervisors and other persons attached to district office - but these are too difficult to count.

Please note the exact pattern would vary from state to state and even from district to district- the only point being made above is that there are number of technical functionaries who are without well defined work and with no regular programme of skill upgradation or in service training.

Training Requirment in a Standard District

Now let us work out the training requirements of this system. This is given in table below:

	In Standard Block of one lakh population - 25 SCs, 3 PHCs , 1CHC	In Standard District of ten lakhs population
ANMs (MPWs- F)	30	300
MPWs- M	15	150
Superviors female	4	40
Supervisors male	4	40
Nurses	4	50
Support staff at PHCs	6	60
Support staff at CHCs	5	50
Administrative posts non medical	2	40
Sub-total (non-doctors)	70	730
Medical doctors	6	70
Specialists	1	15
Adminstrative posts medical	1	15
Sub-total (doctors)	8	100
Total	78	830
AYUSH staff	3	50

Note: This is not the full sanctioned staff strength- merely what is assumed to be available- which is substantially less especially, doctors.

Training Requirement of Medical Staff

The standard district has approximately 15 Class-2 doctors and 70 Class-1 doctors in Government service. These doctors require regular in-service training for the following purposes:

- Training on national programmes, which their formal qualifications and education has not equiped them to handle.
- To be updated on curative care- since the medical field is constantly advancing and in a rural posting one does not have the same access to information as available to the urban counter-part.

- For promotion of rational drug use – and this needs to be repeated – keeping in mind that pharmaceutical companies are exerting a tremendous counter influence.
- For providing on the job training and support for para-medical staff, on various aspects like laboratory work, or BCC work etc.
- For skill up-gradation related to a career satisfaction and to the needs of the facility where they are posted.
- For managing what administrative functions as they are required to handle.

The 20 doctors who are joining this year in our standard district require at least four weeks induction training when they enter service – a completely unattended area. Such induction training is essential to explain their national programmes, their supervisory roles, the standard treatment guidelines and basic administrative and financial rules. The 20 doctors currently in PHCs also have not had any induction training. They need some training to handle curative care roles without peer support and without much laboratory support. This is training centred around the standard treatment guidelines. They need training to be able to train and supervise their paramedical staff on the job. Often, like in laboratory services or family planning programmes, they themselves are not familiar with such work.

The 15 doctors of almost equal seniority involved in administrative roles especially as BMOs and programme officers need administrative training and skills in public health management as distinct from administration.

"Specialist" skills in medical officers: Given the lack of specialists, multi-skilling of both basic doctors and even of specialists takes on urgency. The need for anaesthesia courses so that there is one person with anaesthesia skills available in every CHC, is relatively well recognised. But the minimum set of curative skills that a CHC needs are: in managing surgery for acute abdomen, doing a Cesarean section, blood transfusion and some rudimentary banking facility, neonatal care that can handle pre-maturity, managing basic medical emergencies like snake bites (which require ventilatory support) and diabetic ketoacidosis, emergency orthopaedics, a level of referral ophthalmic, ENT, dental and psychiatric care. We note that all these were part of the MBBS course and most of these areas have even got courses that students have to pass. Moreover, just a generation earlier, MBBS doctors could and did manage this level. However the norms have changes and the MBBS student who now graduate may have passed his/her paper in ophthalmology but would certainly flounder if faced with acute glaucoma case - even in providing basic diagnosis and initiate emergency treatment. The point that specialisation leads to deskilling in areas outside the specialist domain is well appreciated. We however need to recognise that ***specialisation leads to deskilling not only in the specialist but even in the general doctor.*** And that such deskilling has become a major impediment to quality peripheral health services. Imaginative solutions for this are needed.

In addition to the above the system needs to consider a special "cultural" orientation programme for doctors, especially those posted in remote areas – a course which covers ethnic diversity and focuses on cultural

gaps between health care providers and the patients so that they can understand and relate to their work situation and develop an empathy for those they serve. Current attitudes borders on contempt, and this is reinforced by differences of caste, ethnicity, wealth, education as well as vastly different life styles and value structures.

Other aspects of motivation are also susceptible to some improvement with appropriate orientation programmes. Of course workforce management issues are central to motivation- but special programmes for building attitudes can help. Further the health system has to recognise that the "professional satisfaction" of being able to provide professional care to the poor is still a strong, though very latent motivation inherent in the current system. Good skill up-gradation programmes leading to professional satisfaction where the pride of providing good medical care and the stature that it brings to the individual and his family in the community and in the peer groups of the medical community should be built on. Also programmes to mould peer values are required but that would be discussed elsewhere.

"Further the health system has to recognise that the "professional satisfaction" of being able to provide professional care to the poor is still a strong, though very latent motivation inherent in the current system."

Training Requirements of Paramedical staff [1]

There are about 300 female multipurpose workers and staff nurses in the standard district . They require urgent training for the revised skilled birth attendant syllabus. This itself is a three week training. And then they have to undergo an IMNCI training which is another three weeks. Even after this it would be essential to plan for at least 21 days of training every two years. This is for refreshing their knowledge and upgrading their skills and for multi-skilling them. So a lot of the service delivery rests on them, that this is not too much of an investment. They require a number of skills, like in managing deliveries, IUD insertion, etc. They also require updating on all national health programmes, even as it is expected that a number of instructions may change in a period of three years. For example, adolescent health is being introduced this year under RCH – and so on. They also require upgrading in curative skills because they have to respond to peoples felt needs to maintain their credibility. Further now they have to support ASHAs in providing clinical care and this requires that their own knowledge is updated. Then there are aspects like BCC, community participation, gender rights, cultural understandings, training as trainers etc. It is not that ANMs are not trained today – they are the most trained and this is one reason for their relatively better effectiveness. But this training has to be uniformly distributed and all topics covered. Periodic training once in two years for three weeks is the key.

The estimated 150 male workers in the district must have the same levels of training as the female workers, and the training should cover all the same topics except the skills of assisting in delivery and inserting an IUD. It is true that they may be less effective – but that is also partly due to complete absence of training programmes for them. Also the cadre exists, but when it is untrained, there is no possibility of any service delivery outcomes. There is indeed a possibility of using them as support staff.

There are about 80 supervisors who need to be trained, to be retrained and multi-skilled to act as supervisors and fill in gaps in services. They would need all the skills of the MPWs as their primary function is to provide on the job support and training to their workers. If their role is not so understood all monitoring and supervision will fail outright. Supervision has to be supportive. There is no evidence at all that the disciplinary approach that everyone swears by works – and indeed given the problems of governance it would be a miracle if it can work.

Training and multi-skilling of 110 support staff – pharmacists; laboratory technicians; dressers, compounders, and other minimally used staff of the system as well as uni-purpose leprosy workers who are now paid but not at all employed also need retraining and new skill acquisition. Now this is a large number of staff. But still much work does not occur due to lack of staff, and because the staff get dedicated to a very limited work. Thus a busy X-ray technician may have to take about 8 X-rays in the morning – over about three hours – and then there is no work. If the machine is not working there is no work for months. A driver is available when he is not driving. In the PHC there are about 10 to 50 patients- which would mean about 5 cases of dressing per day. Is that adequate utilisation of an employee?

The focus of training of all support staff and male MPWs should be therefore to multi-skill so that they have help or even undertake other tasks. A lot of objections are raised that workers would not cooperate. The evidence is that if this is seen as skill up-gradation, there are no objections from the workers – but the system is reluctant to make changes that remove its excuses for failing to deliver services. Given the multitude of support staff cadre, even with a 10 to 20% vacancy in each cadre one can be almost 100% sure that if this is distributed uniformly 100% of institutions would have one or other critical vacancy. However multi-skilling all support staff increases the efforts and expenditure on training considerably - but per capita costs of training are the cheapest investment one can make. Especially where the costly investments of buildings and equipment have been made there is no reason to withhold this investment. It would also be cheaper than private sector partnerships. Indeed private sector in the case of small scale providers always multi-skills for support staff.

The paramedical staff with administrative functions also require training to complete and understand their functions.

“Multi-skilling all support staff increases the efforts and expenditure on training considerably - but per capita costs of training are the cheapest investment one can make. Especially where the costly investments of buildings and equipment have been made there is no reason to withhold this investment.”

Mainstreaming AYUSH Practitioners

- Recently the programme has laid stress on the integration of ISM practitioners for the public health goals endorsed. This group will also need training.
- These may be trained for curative roles as appropriate to paramedicals, where this is required- and for national health programmes and public health management.
- It would also be useful to train them for many roles that are essential but currently no one plays – like promotive health care, adolescent counselling etc.
- AYUSH knowledge requires upgrading and adaptations.

Community Based Workers

- **ASHA:** Another major focus of the health department would be to train trainers for the ASHA Programme. The ASHAs themselves would be trained near their home villages, and this is dealt with in the module on ASHAs. But to train 100 to 400 ASHAs per block, or about 1000 to 4000 per district, for over a number of years requires about 5 to 20 trainers per block, or 50 to 200 trainers per district and training them would use the training infrastructure and training manpower available.
- **Dais:** Training of Dais is another major training load.
- **Self-Help Groups:** This groups can help and if need to involve them we need to invest in training them.
- **NGOs:** A number of NGOs play useful roles that require training inputs.
- **Panchayat functionaries:** Assuming 30 village panchayats per block or 300 per district in our standard district plus two urban local bodies, the training load would be at least 1500 panchayat functionaries to be trained. All of these require training as they have a major role to play in health care.
- **Anganwadi Workers:** Besides this there are large number of Anganwadi Workers to be trained on health issues.

Private Sector Involvement

- Training is also needed for doctors in the private sector especially in relation to public health programmes and diseases of public health importance.
- Also in certain public-private partnership programmes, skill up-gradation of private sector providers may be part of the package.

It is thus clear from the above that the district has an enormous training load. It cannot escape this minimum load of planning. It would be unfair to state that the public health system has failed unless this investment is made. It is rather that the public health system has just not been tried. One only needs to look at the training system and infrastructure in Tamil Nadu to understand the difference it has made to

health care. The same infrastructure was created in many other states in the same period- but because of negative attitudes to training much of this infrastructure atrophied from lack of use.

To meet such training requirements the district requires good training infrastructure and resource persons and a leadership plan to take care of this training load. And it requires support from state level institutions. Also it will need to enter into strategic partnerships with non governmental bodies or others who can help with this training load. For all of this it needs a training strategy as part of a state training strategy. (see Chhattisgarh state training policy for reference - refer PHRN website: www.shsrc.org).

Let us see how this can be garnered.

TRAINING STRATEGY AND THE DISTRICT TRAINING CENTRE

Medical Officers

- Induction training and certain programme level training can be handled at the district level. This includes training on standard treatment guidelines. The District Training Centre may be able to deliver this. Alternatively the state or regional centres would undertake this role.

- Skill up-gradation training requires centres where practical training is possible and this becomes the key limiting factor. It is ideal to develop at least one hospital (of at least district hospital size with all basic specialties available) in each district – either in the private or public sector for skill up-gradation training. As most districts will not have any such centre, the state would have to designate a few centres for this.

- A continuing medical education programme (CME) – recognising the vastness of areas to be covered is required. A detailed CME strategy needs to be worked out for this at the state level and but for the sake of illustration, we would like to indicate how it might work. The following features could be a part of such a scheme:
  (a) attending CME programmes, organised by professional bodies;
  (b) completing a web-based feedback form or a professional periodical based feedback form or special CME publication that is filled in after studying the concerned section or sections, but there is no pass and fail and only a proof of having read it is required;
  (c) attending training workshops, training postings in special clinics (private or public sector) for acquiring skills like specific surgery or doing ultrasound etc.

- It is possible to evolve a credit based CME system which could be used for promotion policy as well. The CME system would be non-threatening evaluation. Thus there is no one who fails- only

a proof needed of their having gone through the course adequately and reached a certain competency- largely open book evaluations on previously announced questions that can be given whenever the person wants to. The system has the ability to provide a lot of choice in the courses offered, and acquisition of credit points from a wide variety of programmes on offer would be key to acceptance of this programme by the medical officers.

- Further we note that the government is committed to publishing a state drug formulary and a graded standard treatment protocol. Careful introduction and training on this material would be essential and this could be part of the contact programmes of the CME.
- Reducing knowledge and skill acquisition and retention in doctors to some sporadic training camps on a few national programmes is unlikely to make for adequate improvements. For national health programmes like tuberculosis one needs to create general knowledge - skill basis and a mindset - if the goals are to be met. Thus a training programme focussed on tuberculosis disease exclusively would not be able to give enough attention to its differential diagnosis. We know today that about one of ten who visit the PHC with chronic cough have tuberculosis. The TB control programme skills on how to identify and treat the tuberculosis. But if nine out of ten of those visiting with cough are not adequately treated merely because the cough is not tuberculosis, then that medical officer is unlikely to attract enough persons with cough or for that matter enough patients of any sort to the PHC. This common sense well appreciated in private practice is somehow undervalued in the public health facility and this is why a CME approach to training has advantages over the sporadic training camp approach.

- We also need to recognise that due to problems in the nature of medical education, pre-service training does not provide adequate skills.

Paramedical Training

- Most training of the paramedical can be and must be handled at the district level through the District Training Centre. Since there are about 360 persons to train per year (730 staff –once in two years) which is about 15 batches of 25 trainees, even at two weeks average training times 30 to 45 weeks would go in delivering this training. This allows not only to manage the full paramedical training load but also leaves some weeks for training of ASHA trainers and AYUSH staff. This is a goal that is possible to achieve easily, provided the commitment to do so is there.

- The District Training Centre should be able to provide residential accommodation of at least 30 to 40 persons at a time, be able to serve meals and have more than one training rooms. It should have one person in charge and at least three full time trainers. The other trainers can be borrowed from the regular staff for the days when they are required. If the centre is not in use for at least 250 to 300 days a year, the centre is being underutilised.

- Skill up-gradation trainings will however require centres where sufficient patients are seen and tutors are available to provide practical training for skills. Skilled assistance at deliveries and insertion of IUDs are perhaps the two skills where finding suitable training centres are most difficult. But we need to use some care in also selecting sites for training of laboratory techniques, and paramedical curative care skills etc.

- In districts where one needs to start work immediately and the district is unable or unwilling to take on such a burden of work– one can enter into an MOU with a suitable agency , even from a national level, to deliver this training load- and place the district training centre in its disposal.

Community Level Workers and Panchayats

If the District Training Centre is going to be so busy in training its own staff – who is going to train trainers of ASHAs, Dais, NGOs, SHGs, other community based organisations and most important panchayats? Clearly the District Training Centre cannot do so. The only solution is to necessarily have a strategic partnership with at least one or more NGOs, if necessary developing their capacities to provide this training.

Also wherever the annual training load is over 300 it would require to decentralise the training further to take place in the blocks and we would have to develop an intermediate cadre of trainers. Thus ASHAs cannot be trained at the districts – it would have to be at block or sub-block level. For the same reason Dais, SHGs and Panchayat representatives have to be trained at sub-district levels. To create a training infrastructure and government agency would be costly and for training community members ineffective. The solution lies in strategic partnerships with NGOs where they are available.

Of course these NGOs would need to be trained and the District Training Centre could do this - but given their other commitments it may be feasible only for a state level agency to do this. Since the state agencies would be hard pressed to manage the training of trainers for other programmes, even at the state level a strategic partnership like the SHRC may be needed for addressing these sections.

Ayush

For training AYUSH it would be a combination of AYUSH functionaries, the district training centre and the NGO strategic partners.

Private Sector

Training of the private sector practitioners would need to be a combination of the district training centre and a strategic partnership with the professional bodies in the district.

State Level Support Needed for the District Plan

The following is the minimum set of support activities that are required from the state level for the implementation of such a district level training strategy.

1. A clear state level **In-service Training strategy** which defines these tasks so that the districts can go ahead with planning and implementation without taking a sanction each time.
2. An **Active Functional SIHFW** (State Institute of Health and Family Welfare) and Regional Health and Family Welfare Training Centres which:
   a. provide training of trainers for all the above programmes;
   b. develop the standard training curriculum and training material for every training programme. A training programme without good training material is a waste of public money;
   c. evaluate or arrange for independent evaluation of every single training programme conducted by the district training centres; and
   d. help the district training centers plan their training calendar and enter into strategic partnerships where needed;
3. **Training of trainers for Community based Functionaries:** Strategic partnerships with NGOs and Technical Resource Agencies at the state level – who provide training of trainers for community based programmes and reflect critically on and help build up training programmes, and also work on motivation related components.
4. **CME programme for medical officers:** Run directly from the SIHFW in strategic partnership with professional organisations which have been active in promoting public health causes (like the Indian Academy of Paediatrics).
5. **Skill up-gradation and specialist skills programmes for medical officers:** This needs to be organised by strategic partnerships between the SIHFW and such centres as can provide for such skill upgradation.
6. **Restarting/Revitalising:** 6-month training programme of MPWs before promotion as supervisors
7. **Administration and Public Health Management Training:** This needs to be organised by the SIHFW through a strategic partnership with an institution with capacities for training in public health and having practical experience of working with public health programmes.
8. **Intervention in Pre-Service Training Programmes** – One essential intervention especially in government run programmes like ANMTCs is to ensure that their programmes are updated in line with public health programmes – eg introduction of new skilled birth assistance guidelines, IMNCI etc. This is a relatively simple matter. The other is to improve the quality of education in these centres so that we are assured a minimum quality of outputs. This single measure could make a very large difference to quality of service delivery. However this is difficult to secure in government run institutions and a very big challenge in managing the private sector. Again the key is in constructing strategic partnerships- but now for monitoring and assisting in ensuring quality of pre-service training.

Budgeting a Training Strategy

This is a rather straight-forward operation. If we use and MS Excel or otherwise software it is even easier and one can look at different cost scenarios. The table below can be used as a template:

Name of Training	No. of trainees Per batch	No.of trainers Per batch	Per day cost of accomm-odation plus food	Cost of per day trainer fee is any	No. of days	Cost of material per trainee	Cost of travel to and from training camp	Total Cost:	No. of batches to be trained this year	Total Cost for Training
A	B	C	D	E	F	G	H	I = [(B+C)*F* D] +[(B+C) *H]+(C*E* F)+[(B+C) *G]	J	M = I*J
Example: ANM skill upgrad-ation	20	3	150	200	20	100	150	Total= (69000)+ (3450)+ (12000)+ (2300)= 86750	10	867500

I = Cost of training one batch = Cost of accommodation and food for participants& trainers + cost of travel allowance for participants and trainers + trainers fee+ cost of training material.

Anyway drawing up a budget is seldom a problem. The problem really is the quality of the training – the actual content and methodology of a training session. We shall study this is the next lesson.

IN SUMMARY

So how do we make a training strategy for a district?

- Decide on whom to train and on what you are going to train them on. This will also decide the number of days of training needed per batch.
- Decide on who would make the training curriculum and plan for each training (see next lesson).
- Decide on what support you would require from the state (training material, training of trainers, funds).
- Based on the three above- draw up a training calendar for the year- which training will be conducted when?
- Draw up a budget. Then based on availability of resources scale back and prioritise which training is more important.

Review Questions

1. What are the main categories of persons who require training, both in the health department and in the community?
2. What does the term 'multi-skilling para-medicals' imply?
3. What are the training needs of medical officers?
4. What are the state level supports needed for implementing a district training strategy?
5. Draw up a budget for a day training programme for 400 ASHAs in 2 blocks of a district- each batch to have only 30 to 40 ASHAs when the cost of food per day is Rs. 100 and the cost of accommodation is Rs. 120 and the average cost of travel is Rs. 50 per ASHA. A trainers fee is Rs. 200 per day.

Application Questions

1. If there are AYUSH practitioners playing the role of the medical officer how much training would be needed? Can there be a separate training approach to address this section?
2. Can one District Training Center manage so much training work per year? What would be the possibilities of getting more partners to manage part of this training load?

Project Assignment

1. Examine a few district plans. Which of the above training requirements are met? Which are not? Find out why this choice has been made?
2. Draw up a training strategy for a 5 block district to ensure that all the persons who require training are trained as needed within three years. Work out the costs of such training. Prioritise programmes and budget such that it fits into a budgetary allocation of Rs. 25 lakhs.

1. The term here includes nurses, MPWs and supervisors and technical support staff.

NOTES

Lesson SIX

Designing a Training Programme

In this lesson we shall discuss:

- Assessing training needs
- Defining training objectives
- Choosing training methodologies
- Preparation of training material
- Training evaluation

INTRODUCTION

The design of a single training programme has several aspects that must be considered distinctly fror drawing up a district level training strategy. Many factors go into planning a successful training programm as a part of a health programme. An understanding of what should be training content, who would b giving the training and who would be getting the training, needs to be looked at in detail. Further, issue such as what resources are required to organise and conduct the training, where would the resources c undertaking the training come from, and what are the available resources, all need to be understood an based on this information the training is planned.

In planning a training programme we have the following steps:

1. Undertake a training needs assessment, current competencies, number of trainings held in th past on the issue
2. Define competencies and objectives of the training programme
3. Understand existing budget/resources available for the training
4. Assess quality and usefulness of existing training materialDevelop or collate training material fo trainers and traineesDevelop evaluation instruments for training sessions
5. Identify trainers from within the department and outside according to budget availability and flexibilit
6. Identify venue, time, accommodation and costs per unit of training : Ensure that it matches availabl budget. Plan for creating an enabling environment for the training.
7. Draw up a session by session training plan for the entire training workshop. Decide the trainin methodologies through which each competency would be acquired. Ensure use of innovative trainin techniques, for example use of ice breakers, learning games, practical and field based learning
8. Training of Trainers : focused on knowledge, skills and communication and on training techniques
9. Monitor ongoing training to make adjustment and evolve training design for next rounds. Mak provision for feedback from participants
10. Evaluate training outputs on basis of process indicators and outcome competencies.

We elaborate on many of these steps below.

ASSESSING TRAINING NEEDS

a. What services need to be improved? Before one begins to plan a training programme for the distric it would be critical to find out from each programme of the health department, the following: What i level of performance of particular service? In contrast what is the desired level of performance? Wha lack of skills or knowledge or attitudes have been constraints on the delivery of these services?

b. Define and understand what competencies are present in the trainees and what are not present:

c. Training experience of the recent past:

   i. How many trainings have taken place in the past three years?

   ii. Who were these trainings for? Were the trainings for all levels of health functionaries; what were the 'generic' trainings – applicable to all workers? What were the specific trainings given to each level of the functionaries- i.e. doctors, ANMs etc.?

   iii. Obtaining feedback from programme functionaries on previous trainings - understanding their satisfaction with the knowledge imparted in these trainings.

   iv. What all had been addressed in their trainings, what else can be built into these (i.e. training on communication skills etc)?

d. What would the participants themselves like to learn (Often doctors seek updates on current issues in medicine) or what would they wish to revise (i.e. technical skills, knowledge of issues)? What refreshers are required?

Of all these, first two are critical - what services we are seeking to improve and what are the current level of competencies as compared to what is needed for effective service delivery. It would also be important to prioritise training programmes, on the basis of the priority of health issues in the district, for example the urgent need for malaria management during monsoons. It is only after considering these issues, that any new training should be initiated.

FRAMING OBJECTIVES OF THE TRAINING PROGRAMME

Framing of objectives for a training process is synonymous with defining competencies to be attained through the training process. There could be different forms of such competencies:

A. Technical and Practical skills:

These form the bulk of the work undertaken by a majority of the functionaries in the health department- ranging from doctors, to paramedics such as the ANM. Within this one would need to assess their current competency on the technical knowledge and skills, and accordingly build up a training programme.

Examples of such training objectives could be :*(the lists of skill-sets are not complete, and are examples*

1. Skill sets of ANMs	a. Being able to manage complications at child-birth that do not require surgery. b. Being able to provide first contact care for birth asphyxia, c. Being able to understand and follow the necessary cautions to maintain the cold chain from the time she draws the vaccines to the time she returns it to the ILR. d. Being able to provide first aid for simple emergencies and first contact curative care as defined by the standard treatment guidelines for paramedicals.
2. Skill sets of MPWs	a. Being able to do urine examination as part of antenatal care and to grossly assess for urinary infection. b. Being able to do a blood examination for anemia and for looking for malarial or filarial parasites. c. Being able to understand and follow the necessary cautions to maintain the cold chain from the time he draws the vaccines to the time he returns it to the ILR.(Ice lined refrigerator) d. Being able to provide first aid for simple emergencies and first contact curative care as defined by the standard treatment guidelines for para-medicals.
3. Skill set of supervisory staff	All the above skills plus: o Being able to collect and analyse data from a 30 cluster sample survey to evaluate coverage. o Being able to train staff under him on the job on skills they should have and for BCC activity.
4. PHC Medical officers:	All the skills needed to provide curative care at all the levels indicated

B. Management and Administrative Skills

Every person in the health department is expected to look into certain administrative issues and also manage and report a certain amount of data. It is then critical to look at building competencies on the following issues:

- Overall administrative competency – understanding reporting structures and approval flows.
- Data management : understanding the MIS, efficient record keeping and reporting.
- Stock/warehousing management as well as of an inventory system.
- Effective management of personal, communication training for all levels.
- Hospital administration and management for the district hospital team.

C. People Skills

Health personnel at all levels require competencies in the inter-personal skills of organization and negotiation. For example, in building convergence between departments at the field level, or in coordination with panchayats there are many persons with equal power and influence who need to be coordinated with. There may be a need to motivate them or influence them to provide support or work together for some select goals. Thus an ANM would need such skills for interacting with ASHAs, with anganwadi workers or with Panchayat leaders. A Chief Medical Officer in a district would need such skills for interaction with the District Collector, with senior officials of other departments, with service organizations etc.

The other competency that becomes important where different people are working together is leadership skills. The team members tend to follow the role model set by the leadership. And making all members of the team take pride and ownership in the outcomes of a programme or task and put their full effort into it, requires leadership skills. Building up a sense of mutual solidarity, and of motivation is also part of this.

These skills become even more critical in relation to the interaction of health system functionaries with the communities. It is very important for all public health functionaries to have good people skills in their relations with communities.

UNDERSTANDING COMMUNITY ISSUES AND BUILDING COMMUNITY PARTICIPATION

Another competency that needs to assessed and addressed in the public systems is the capacity of the functionaries to be able to understand issues of community dynamics of caste, class and religion. This becomes fairly critical in the context of issues such as the operationalisation of the ASHA programme. In states and districts were selection of the ASHA is to be undertaken by department functionaries at the block level, there is a critical need to be well aware of these social dimensions existing within a community

and then initiating a fair, equitable and representative process of selection. It is important to have this competency at the time of training programmes also, so as to ensure that no worker has been discriminated against on the basis of caste, gender etc. Besides, an understanding of community needs is important for the effective design and implementation of all health programmes, for determining the services that are needed by the community, for determining utilisation of these services and for addressing the barriers to access these services.

Case Study: Understanding Competency requirements

In the district of West Singhbum, Dr. Clang, the chief medical officer was made aware that all blocks had reported cases of malaria in the month of November. He needed to make a decision on whether to manage it as an epidemic. Other officers had differing views. A few thought it was an epidemic. Others felt that a peak in winter was well known and panic need not be created by calling it an epidemic. After all so far no newspaper had picked up any stories of the deaths and higher incidence of malaria cases. He looked into the MIS for the past month and noted that there was rising number of malaria cases- from 800 in October to 1200 in this month. He compared to the previous year and found that it had then gone up from 700 cases in October to 1000 cases in December. This was the pattern in 4 of the 5 blocks. In one block which was more of a "plains area", as compared to the other blocks, the cases were much lower and there was no rise. He decided not to call it an epidemic publicly– but take action precisely as if it was one. To manage this epidemic he undertook the following steps:

- Called a meeting of the block medical officers and all programme officers of these 4 affected blocks at the district level and then a meeting of all the supervisors. In this he gave a clear set of instructions and protocols on what indices have to be observed daily and what weekly and whom they must each report to. And what actions to take where the indicators crossed a threshold level.
- He also did an immediate assessment of stock position in all stores of these 4 blocks and came to the conclusion that though all stores had stocks it would not be enough if the fever incidence continued to rise. He got some increase in supplies from state stores and some drugs for the CHCs that he got procured locally.
- He conducted a quick refresher for two days for all sector medical officers on malaria epidemic management. At least six hours were spent on increase in their skills at microscopic diagnosis- for which he had got a good laboratory technician to prepare 100 slides of which 50 were positive and used these to train the medical officers. He instructed them to be able to supervise many operations including ensuring that slide reporting was of adequate quality in their facilities- if needed training one staff locally for that purpose (as a stop- gap measure). Also distributed all available rapid testing kits so as to use it where it lasts.

- Then he talked to the district collector and called a meeting of the district health society where all key departments were represented to discuss the problem and followed this up with a meeting of all the block level supervisors to plan a massive fever survey on fixed days across each block.
- He also asked all the ASHAs to help hold village level meetings in these 4 blocks to help plan and seek their cooperation for the mass survey. One health worker staff would attend each of these meetings and help the ASHA.
- Then on a given day survey teams visited every house in these 4 blocks and wherever there was a person with fever made a blood smear for examination and gave them a full course of chloroquine, the first dose of which they had to take in front of the team itself. This dramatically cut through the epidemic.
- In those villages where the blood smear reports were very high, spray teams were sent and a BCC programme organized to promote bed-nets in the very next week.
- Also from the day of the survey a control room operated which received information on the pattern of blood smear positives – section by section (cluster of villages). Wherever the incidence of malaria crossed a threshold level, the following week another survey would be organized.

Discussion

Of course there are many places where a response to a malaria epidemic is neither so prompt nor so thorough. Often there is just a state level decision to do a mass fever survey every month for three months in the entire district. There is no attempt at mobilizing other departments or even the communities each time for the survey. Also there is no specific context, no reason to actually suspect an epidemic and therefore everyone takes the mass survey very lightly and goes about it in an incomplete and lackadaisical manner. This does not matter much; except that when really an epidemic strikes people still treat the mass survey in the same manner. Clearly the approach in the case study requires a number of competencies whereas in the other "routine" approach much less was required.

List all the competencies that would have been required of a CHMO in the above example. Which of these are technical competencies, which of these are managerial competencies and which are people skills? How many of these would a CHMO be having? In a training plan for CHMOs how can the required competencies be built in?

DEVELOPING TRAINING MATERIALS

For undertaking an effective training it is important to bring together – good training material; both for the trainees and the trainers, innovate with training methodologies, and also build in good evaluation methodology to understand the effectiveness of the training.

While a series of 'modules' or 'books' pertaining to various thematic aspects of the programme has become the norm for community health programmes, other types of material such as posters, flip-charts, pictures and even the use of audio-visual material is also used as training-aids during a training session. These together constitute what we call training material.

Why do we need good training material?

- To ensure that the competencies required as outcomes are built in and adequately emphasized in the training sessions.
- To ensure that in training cascades and in training design where we have a stage of training of trainers- there is no loss of content of the programmes as the training proceeds to the next level.
- To ensure that concerns of gender equity and other equity and social dimensions are built into the training programme- even in programmes which are apparently only technical in nature. Such concerns tend to be lost in a training cascade as there is not uniform sensititsation to these issues at different levels of the training pyramid.
- To provide audio visual material that helps enhance the quality of learning.
- To provide trainess with material that they can use as referral and reminders of what they had learnt during the training programme.
- To provide a commonality of content and approach amongst many trainers and a ready guide to what is expected of them in each session.
- To act as a tool that helps in training evaluation.

All training programmes conducted without training material where each trainee was issued a copy of the training material –are suspect. Such training programmes are unlikely to yield outcomes except in certain exceptional circumstances and with some exceptional trainers. As a rule in a department conducted large scale training programme using a training of trainers step- we can take it as a general rule that training without training material was inadequate and incompetent training.

Broadly training material developed is of three categories:

1. **Trainee's materials:** For any functionary it is important to have some reference material, which is self explanatory and comprehensive on the issue that he/she is being taught. Trainees materials should be developed after an understanding of the learning competencies of the trainee. For example, training

material for semi- literate, community based health workers (ASHAs in the context of the NRHM), should explain issues through an emphasis on visuals. The use of stories, pictures, diagrams has seen to be more effective in teaching these workers.

2. **Trainer's guidebook/note stating methods:** The effectiveness of a training programme is critically based on the effectiveness and quality of its trainers. to undertake an effective training – it is important to ensure good quality trainers who have good training and communication skills. Every trainer needs to know what competencies have to be built up in each trainee. Every trainer needs to know what method or methods she/he would use to build up these competencies. Every trainer would further need to know when in the training session this particular competency would be addressed. Finally every trainer has to be able to measure whether this competency was built up. This is the core of what goes into a trainer's guidebook. This may be remembered as the what, how, when and whether of competency acquisition: what competencies to build up, how is it to be built up, when is it to be built up, and whether it was successfully built up.

This implies that training material lists the goes beyond listing the competencies to be acquired and details of the knowledge and skills which are also present in the trainees guidebook to discussing the training methodologies to be used.

Training methodologies need to be engaging and exciting and specifically designed for particular groups. Use of stories, role plays, and positive and negative deviance stories, all can be used as training methods. Processes such as "training for transformation", which emphasize self discovery and awareness about social realities and practical usage of the knowledge can also be built into training methods. Learning from peers and a phased training plan with continuous support, and a flexible learner-centric approach should also be understood as a method of training.

It also means that training materials may consider incorporating a session by session training plan (the when of competency acquisition) and the protocols for training evaluation. This is important for training evaluation to be non threatening and useful to improve quality of training.

Besides these four dimensions of training material, trainers need to be competent and have higher levels of knowledge and skills in a particular domain than the trainees, so that they can inspire confidence. Of course this is not as essential as sometimes it is made out – for the trainer can be better equipped only in some domains, while in other domains the trainees are sure to know more. The modesty of the trainers and his ability to interact with his trainees respecting them as equally well informed and rational and creative human beings is even more important. The trainees would also need to know some aspects of management of training logistics and organization - choice of venue, accommodation and food arrangements, payments, training environment etc. These may be issued as instructions at local level rather than incorporated into the printed trainers handbook. However they are also in that sense important training material."

3. **Training Aids:** Video clippings, Posters, flipcharts, charts, pictorial books etc can act as training material.

THE DESIGN OF TRAINING MATERIAL

The content of the training material:

i. should include all the key information that the trainee has to acquire (largely in trainees material)
ii. should include some of steps in the process of skill acquisition (some of it in trainees material and a lot more in trainers material. Actual skill acquisition is usually based on guided practical work and is not text dependent.)
iii. should have visually appealing presentation of these issues in a combination of text-and-illustrations, facilitates the use of the modules in effectively transmitting the knowledge and message to trainees. This is especially important for audio-visual aids.
iv. should provide opportunities for dialogue and interaction is another important dimension of the training programme: These could include:
    - Questions pertaining to the theme
    - Presentation of case studies
    - Seeking information from the participants pertaining to their own location and context.

These are all devices in the material that facilitate engaging the participants in a dialogue in the training programme. These exercises also facilitate reflection, discussion, and group work – which may act to reinforce the central message of the programme. For example, a training module on health, which includes a section on the absence of access to transportation during a medical emergency, may also include an exercise asking the participants to cite examples of their own geography or their own context and ask participants to discuss the problem and ways in which each of them may attempt to solve it. Thus the content of training modules presents not only information and analysis, but also suggests ways in participants may take action based on the problem analysis that they have just arrived at or have learnt about.

Some of the key objectives of arranging the content in the modules in a non-didactic manner, and indeed the aim of every training programme, should be to 'involve' the participant in the subject, to give the participant the opportunity to reflect on his/her own context and reality for virtually all aspects of the subject, to constantly engage the participant in an analysis of the issue, and most importantly to not end up alienating the participant.

LAYOUT AND ILLUSTRATION

Different techniques of presentation of the content can be used. A good presentation of the material is one that catches the readers' eye, which highlights at first glance the basic theme or the topic, but also

generates the readers' curiosity to examine the detail. Indeed, in designing a module, attention must be paid to every page. This is best done by professionals. Usually the person who knows the content must interact with a professional who does the page layout on computer and a professional who is an illustrator-artist. But if costs of hiring professionals are prohibitive or in a district context they are not available, and there is someone with the interest and some basic skills, one can have a go at it. Studying different professionally done layouts and using one of them as a template is a good way for the amateur to get started.

An interesting way of presenting material, one that also has interesting visual possibilities, is of using the image of a central character – a person, perhaps a woman, who appears to 'interact' with the reader at various points in the module. The introduction of the reader to a particular topic is 'narrated' by this character, and this can be depicted in the module using a text-box. This character, who will effectively the narrator of the topic, leads the reader through the text into descriptions of a village or a home, and to understanding different aspects of the topic. The same character may then be used as the person participating in the case studies – interacting with people in the case studies – or as asking questions to the reader to review.

The technical nature of some aspects of health and/or the sheer amount of information that one is keen to introduce through the module may mean that the module has a large amount of text but fewer illustrations or exercises. It is important to note that the two need not be mutually exclusive! It is possible to arrange text quite creatively around sketches and pictures, without giving the viewer the impression that the module is a large amount of written word. Once again, interactive exercises for individual as well as group-work may include analysing a particular illustration, for instance that of activities around a village pond, or of activities in the sub-centre of the PHC, in detail. Illustrations that are drawn well (that also print clearly!) are an excellent way of engaging the participant with the subject of the module, because it is a visual representation of the matter and helps the participant recall similar images from his/her own context.

One key aspect to remember here: very often, training material works as reference material for both trainers and trainees after the actual training programme is over, and is referred to, from time to time, when one needs to refresh some key aspects or information related to the subject. At this time, a well designed, easy-to-read module will be very useful.

Wherever possible, use designs and illustrations that belong to local cultures and traditional art forms. Even when translating the book – 'translate' or adapt the pictures as well. Not only will the modules give a sense of belonging to the state's or district's health programme, participants will easily identify with these and see them as their own, rather than as more distant or 'foreign' to their culture and reality.

THE PRODUCTION OF TRAINING MATERIAL

The key issues to decide about printing are :

a) The quality of paper and use of colours
b) Number of copies
c) The tendering process and monitoring printing quality
d) The warehousing of books and their distribution logistics

a. Quality of Paper and Colour: There are wide variations in the quality of printing, and the costs related to printing – based primarily on the use of colour and the quality of paper. There are very interesting possibilities even with two-colour printing and this could be explored. Also find out how much difference there is in costs between multi-colour printing and two colour and mono-colour. The difference may be small and not worth the loss of aesthetic appeal.

b. Number of Copies: One aspect to keep in mind is that enough copies should be printed so that every participant in the programme – all trainers as well as trainees – should be given one copy each. It is also useful to print some additional numbers (approximately 5-10%) so that lost/damaged modules with participants can be replaced without much delay. Copies may also be shared with key people in the government departments and sent to the State Health Society/Resource Centre as well.

c. Tendering process and the quality of printing: One of the key issues is the decision of whom to give to print. Curiously there is a disproportionate interest of some of the most powerful sections of the health system to this aspect of the training process. Since the skill sets needed for deciding and acting on this is entirely different from the rest of the training process many otherwise successful training organizers fail on this step. One needs to develop unit costs (per page) so that budgeting and note-sheets for approval are well made. And one needs a draft tender document or even a print order placing template – so that all aspects of quality of printing are fixed. This reduces the chances of being fleeced in price and quality an helps compare better between quotations. Institutions like NCERT or NBT have standard procedures and order templates that could be used.In most places this aspect of training is taken over by the senior most persons in the system or given to a government clearance agency built for this purpose and this saves a lot of effort and pressures on the system, though generally the prices would be about 50% more than on the open market.

d. The warehousing of books and their distribution logistics: In large state level programmes this is a major problem. The main reason is a complete failure to visualize the space needed to stock and the systems needed to maintain a large stock of books. Also the skill sets needed for this are so different from training skills that very often training programme managers selected for their training skills come to grief in managing the stocks. Distribution of training material , preventing wastage and leakage along the

way and ensuring that the material are available where they are needed , when they are needed can be a huge task, especially in a programme like ASHA, where provisions for programme administration are minimal. SHRC Chhattisgarh, for example, had to hire a godown space, learn to stock material, develop inventory management systems and work out lowest cost distribution options to send books for different training rounds in a timely manner - not an area of competence it had when it started out.

Finally, it is important to remember that the 'material' is an important, but only one aspect of any training programme. The production of excellent training material does not automatically translate into an excellent programme. The human element in training, i.e. the trainers, and their interaction and relationship with the trainees, are equally if not more important. Good training material will engage both trainers and trainees with the subject as well as the process of learning.

CREATING A LEARNING ENVIRONMENT

The venue and time any training should be set in convenience to those who have to participate in the training. While it may be good hold district doctors' trainings at the district hospital, it may not be a good idea to hold ASHA trainings at the district levels. Prior information definitely needs to be provided to the trainees and accordingly permission needs to be sought to attend the trainings.

The venue itself needs to be a place where the trainees can sit comfortably and which in summer is not too hot. Toilet facilities are important and far too often, toilet facilities which are clean and which women can access are not arranged for. A surrounding of cleanliness and calm, where in-between sessions people can walk around would be add significantly to training outcomes. A visit to the District Training Center should therefore tell us in a glance how seriously training is taken by the district (health) administration.

Also welcoming banners, a banner behind the podium, charts and posters on the wall, etc. create a right mood. As does someone is welcoming trainees with warmth, registering them politely, conducting good round of introductions and ice-breakers, serving refreshments and meals on time efficiently and generally maintaining a spirit of good humor and friendliness. It is in such an enabling environment that the mind can concentrate on and grasp best the serious content of the training programme.

Training of community representatives has its own requirements. For example when training women who are community representatives, a day care center for those women who cannot leave their children at home becomes required. Food arrangements would therefore have to be flexed to feed more people than can be accounted for officially. Timing would have to be chosen keeping social and religious events and crop cycles in mind. Songs and group activities that build mutual solidarity would all be essential aspects of building a learning environment.

DELIVERING TRAINING: TRAINING METHODOLOGIES

Training methodologies need to be engaging and exciting and specifically designed for particular groups. There are different well known techniques and it is important to know what technique would be appropriate to the competency that needs to be imparted. Broadly we discuss training as being practicals and field based training as one category and class room training as another.

There are some critical aspects in delivering any effective training. These are:

- **Effective communication:** Trainers need to be articulate and clear about the knowledge they wish to impart to the trainees. Different ways of enhancing communication can be used. Use of media – such as films can also be used during a training session. Visual media such as flip charts, models etc can also be used. Besides these the trainer should speak with confidence and be able to engage the audience and also make them comfortable with the subject.

- **Participatory Training:** In addition to trainers feeling confident about speaking in a training session, all trainees also need to be comfortable to be able to question and understand the issues being taught. To initiate active participation, trainers need to use different techniques including games and friendly forms of introducing each other within the training group, so that all the participants reach a level of comfort with each other. As discussed above, if the training programme is made interactive, the trainer should be conscience of playing a leading-facilitation role, where he/she allows the participants to express their feedback, doubts and questions. Learning from peers in addition to learning from the trainers should be understood as a desirable method of training, irrespective of technique used.

- **Facilitating Participation:** The trainer should also try to engage every participant in the proceedings of the programme, and be aware of the need to balance the interactions between participants who are more articulate or dominating and those that regularly do not volunteer their views or answers. This may require an adequate number of trainers. Therefore though one trainer may do the main presentation in a given session, it is best a small group of three or four trainers who should conduct all the sessions – as a group being available for interaction. Every trainee should have got opportunities to speak- giving feedback, revising learnt information, or seeking clarifications- or had opportunity to do things in the training programme.

PRACTICALS AND FIELDWORK

- Practicals are mandatory for Skill acquisition. Where there are no practicals – skills cannot be considered to have been acquired. Thus if ASHA has to learn to make a blood smear for examination for malarial paraisties there is no substitiue to each and every trainee doing at least one such

procedure themselves. Audio-visual aids, including video amy reduce learning time and improve training quality but do not substitute for doing it themselves in real situations. Thus one has to think a lot into how such practical training would be imparted. Thus if an ANM or a dai is being trained for birth assistance, their managing a few cases of child-birth under supervision is mandatory. This brings considerable limitations on how many can be trained and where they can be trained- but that has to be accepted. Thus ASHA can be taught counseling skills on the field visit .But since it is unlikely to find children with pneumonia readily to demonstrate, one needs on the job training visits frequent enough to help her identify one such person and manage it under supervision.

- Even those which are not so technical skill based, and are apparently information based, require the practical application of the learning in the context of its purpose. Thus field work becomes important even for information transfer- as way of contextualizing knowledge and raising it to a level where critical reflection is possible. Thus one can take a class on the functions of a PHC or CHC, but if this is combined with a field visit to a PHC or CHC the quality of learning is enhanced. The usual example given is of the person who was taught swimming in a classroom -complete with audio visual aids. However the first time when he had to get into the water to his dismay he found that he was drowning and had to be helped ashore. We can understand this example for a skill like skill birth assistance but we need to recognise that it is relevant even for a simple piece of information like what are the functions of the PHC.

- Ideally, different classroom based learning modules in all training programmes should be spread across a period of time, rather than be taken up one-by-one on continuous days. For field based workers, the interim period between classroom-based or contact sessions can be organised into various aspects of fieldwork – i.e. components of applying what they have learnt, at the community level and then come back with experiences for discussion and further nuance their learning.

- Most on-the-job training is of this category. Thus the regular supervisors visit to the the worker whom he or she is supervising must always be used an opportunity for field based training. Here it is the analysis and management of a real situation that becomes the training method. Skills also can be taught on the job and indeed must always be reinforced through on the job supervision. Supervision without training is "authoritarian" and usually ineffective.

TECHNIQUES OF CLASS ROOM TRAINING

Lectures: These are useful for conveying information systematically and giving a good overview of a topic. Good lecturers know to modulate their voice, keep good eye contact with their audience, intersperse lectures with interactive questions and dialogue and use humor effectively. They use repetition to drive home a few points they need to make - instead of making the presentation dense with information. The

use of audio visual aids and the distribution of written texts of the information are very valuable - especiall if the text is available and has been read before the lecture.

Its disadvantages – even where there is a brilliant lecture delivered - are mainly that though they give a impression of good learning achievement, measurement shows that a very high percentage of th information is quickly forgotten. One therefore needs to have other forms of reinforcement of the informatio if a lecture has to be useful.

Small Group Discussions: There are many ways of doing this. One usual technique is after a lecture, t divide into small groups and discuss some key questions that arise out of the lecture or on a given topic The questions could be circulated and discussed before the lecture. A trainer could act as a moderato Thus if there are 30 trainees there could be five groups and one trainer would sit with each. Readin through and discussing the training material is also useful. If the number of trainers available is few the the groups may choose to present a summary of their discussion through one member of the group i plenary session, following the small group discussions. As each group presents their views the othe groups react and the trainer is able to sum it up. The advantages of the small group is that it allows one to-one interaction, allows everyone to read the material and speak about it and express disagreement and seek clarifications, etc.

Training trainers to moderate small group discussions effectively is an important component of training o trainers.

Group Work: Here the group is expected to go beyond discussion to work on achieving some output as a theme. It may be the preparation of a chart or a poster, or a small play. It may be a small field survey o case study. Devising group work to reinforce various aspects of learning is an useful way of providing a break and assisting in internalization of the received information in the forms of general concepts.

Role Plays: This is a specific form of group work, used best to discuss attitudes and perceptions and interpersonal skills. First, the group is told the issue being addressed and various trainees of a small group are allotted different roles to act out a given situation that exemplifies the issue. This stage is called the briefing. Then the group after a minimum preparation acts out their parts, feeling free to develop the situation as each person feels fit. This brings out a whole set of issues, sometimes some of them are emotionally charged or unexpected. This is the role play stage. Then the group is formally stopped and a break is given. In this stage the audience and participants discuss the perceptions and attitudes on a given issues as emerged from the presentation. In training on certain issues such as gender mainstreaming or counseling skills, role plays are invaluable. But it requires good facilitation. Even with good facilitation role plays would not be a preferred technique for many forms of information and skills.

Case Simulation/Case Presentation: Here a real life situation is simulated, either acted out, or shown as a video clip or even a real life story is presented. These may be positive or negative deviance stories. The group then comments on this and discusses the issues that arise from the case.

Personality Building training: Processes such as "training for transformation", emphasize self discovery in the context of awareness about social realities. They require special skills and trainers with considerable understanding and maturity. In specific contexts such training can be useful.

MONITORING AND EVALUATION OF TRAINING

Feedback, Supportive Supervision and Post Training Support

Receiving feedback from all trainees is a very important aspect of a training programme as it serves two main purposes – (1) it helps identify areas of the training programme – primarily related to the content, methodology, and comfort levels of the trainees with the training and its application – that may be improved upon in subsequent training programmes, and more importantly, (2) it helps identify the areas that need to be reinforced or revisited in subsequent refresher sessions if these have been planned. Ongoing supportive supervision is extremely useful for making learning stronger. It is always useful to make adjustments keeping in view the feedback from trainings sessions, of what needs to be done differently.

- Once training has been imparted it is very critical to provide support to the trainees so that they can translate their learnings to their work.
- Building confidence to use their knowledge should be encouraged by peers and seniors to those who have undergone a particular training.
- Refresher trainings and on the field trainings should also be provided to trainees.

Evaluation

Evaluation is a critical part of any training programme. This should not be confused with feedback on the perceptions about the training process from the participants – which is one part of training evaluation- but not its main part. Training evaluation is a process that assesses whether the competencies aimed for have indeed been built up. Another related issue is whether the increase in competency lead to an improvement in service delivery or whatever function the trainee was expected to carry out. Evaluation can thus be:

a. Training Output evaluation: This is what is usually referred to as training evaluation.
b. Field based evaluation of the training output: To ensure there is retention of knowledge and skills after a training programme, along with follow up that knowledge and skills are retained later, and not merely present at the time of leaving the camp.

c. Training Outcome Evalution: whether the service delivery, which is expected to impact on healt outcomes, improves.
d. Process Evaluation: To ensure key steps of the training process was carried out and with desire quality.

Evaluation Approaches

- This could take the form of questionnaires that each trainees has to fill or a small multiple choice or short answer based examination paper. The score of the batch as a whole for each question has then to be tabulated and this is the true reflection of the learning that took place on each competency area. The score of each trainee is also useful – to plan follow up programmes and in case there is certification of training required to decide on certification in an objective manner. We however need to remember that evaluation is not primarily an evaluation of the trainee - it is primarily an evaluation of the trainer.
- In participatory training evaluation there is a moderator facilitating a discussion of what has been learnt. Various participants are given a question each to answer and others contribute to the answers. There are different techniques of such evaluation- which are better suited for small training programmes. Not suited for the more impersonal large cascade trainings.
- Training evaluation could be group based and in the form of oral questions and answers.
- Skill based training could be based on documentation of the number of procedures done under supervision as certified and cross-checked. This may go along with the first question paper form of evaluation on some key aspects of the procedure.

Keeping it Formative and Non-Threatening

Training evaluation should be non threatening. It is primarily meant as a way of improving the current training – not only the next. Thus the question paper must be shown to the trainers who know exactly on what they, as trainers, (and not the trainees) are going to be evaluated.

The question paper could also be shown to the trainees as a pre-test evaluation especially if we are doing upgradation training on an area where they already know something, for example, a nurse being given skill birth assistance training or a doctor receiving training on TB case management. This draws their attention to what they do not know and since they are informed that the same paper would be re-administered they know what to focus on.

Tabulation and analysis of results question by question and retraining on areas where the entire group has not learnt much is also essential to the process. Thus formative training evaluation at intermediate stages in any training programme which is over three days long – is mandatory. At the end of the training programme there could then be a summative evaluation.

The documentation of training evaluation should feed into the training programme continuously for corrections, contextualisation and improvement. In evaluating training, qualitative feedbacks from the learner should also be an integral part.

Process evaluation can be understood on the following paradigms:

- Use of participatory learning techniques and systematic daily feedbacks from the group.
- Emphasis on monitoring whether key steps like group discussions, field visits, or practicals took place.
- Records of the training process- attendance, notes, accounts etc.
- Formative Evaluation of trainers knowledge and competency.

Evaluating for Training Outcomes with Relation to Service Delivery

This should be done both immediately and after six months or a year of the training programme. Every training is meant to provide an increase in quantity or quality of services provided. It is important to document whether this took place. If it did not improve, it may be due to other factors- if the output indicators- both immediate and long term are adequate. However if we find that after six months the knowledge or skill levels have dropped then it is still related to the training design. Thus an ASHA taught to do a blood smear for examination or a medical officer taught to do a Cesarean section may both have had no opportunity to use the skill for six months and when finally after nine months an opportunity comes their way they may have lost the skill. Thus the training design should have anticipated and built up a way of keeping the skills alive by a suitably designed follow up plan. The ASHA could have been allowed to make some slides during the monthly meeting or supported by the trainer during a village visit to start this activity in her habitation. The medical officer could have been arranged for to perform two elective Cesearean sections in the district hospital under supervision every month, till institutional delivery picks up and C-section opportunities emerge in her FRU.

Thus service delivery outcomes related to long term skill retention estimations are essential for a complete evaluation of a training programme and must be built into every training programme.

Review Questions

1. What is a competency? How is training objectives defined in relation to competency?
2. How do we use measurement of service delivery improvements to assess training outcomes?
3. What are the key steps in training material development? Why is good training material essential to the training process?
4. What are the advantages and limitations of group discussions, lectures and role plays as techniques of training?
5. What are the requirements for training for skill acquisition as different from knowledge acquisition.

Application Questions

1. List all the competencies that would have been required of a medical officer and a MPW and an ASHA in this above example of managing a malaria epidemic- given as a case study in the text. If we planned a two week periodic refresher what would be the training objectives for each of these staff.

Project Assignment

1. Design a training programme along with a calendar of activities for IMNCI in the entire district.
2. Design a training evaluation questionnaire that can be used to assess ASHAs trained in the first module.

Lesson SEVEN

Skill Upgradation: Addressing the Gaps in Specialists

In this lesson we shall discuss:

- Why skill upgradation for specialist skills is proposed
- The broad approach to multi-skilling medical officers on different specialist skills
- The areas where such multi-skilling is needed

THE LOGIC OF THE APPROACH

First examine the question: Do we need a specialist in every one lakh population? Will he or she have enough work? How often do we have diseases that a community health worker, a trained paramedical or a general medical officer cannot manage but that requires a specialist that can be managed at the secondary care level – like a reasonably equipped CHC?

If the numbers are high, then providing transport to a district hospital cannot solve the problem. We need to get a specialist in place. We know that approximately 15% of child-births will have complications and 5% will need surgery. Thus in one lakh population, there are 2500 child births and 125 avertable deaths per year. If we add the needs for MTP and sterilisations (not considering, for now, RTIs and early diagnosis of cancer etc.) the need of the gynaecologist is clearly present. One can show similarly that a number of the basic specialities are needed.

The next question: Can we get specialists to go there? From either the private sector or the public sector? In most of the EAG states there is little possibility of finding the requisite specialists. The number of specialists generated per year are very small and of these, though who join government service are even less and of these though who would go to interior areas is even less.

Can we outsource it to the private sector : Certainly, wherever possible. But in most of these places where there is no specialist in the public sector hospital there would be none in the private sector as well. And private sector would also find it cost ineffective to bring in doctors there for the few cases – if it has to do it for the profit motive alone. Not for profit hospitals – mission hospitals, trust hospitals, public sector undertaking hospitals have been able to do better – but they are able to cover only a limited area. To that extent they can be used. But this would still not be a general solution.

MULTI-SKILLING MEDICAL OFFICERS

One workable solution is to go back to ensuring that MBBS doctors are skilled to be able to provide these services. Whoever is willing to work there – the skills needs to be built up in them.

This can either be by giving all of them preferential access to post-graduation especially the Diplomate National Board examination. But post-graduation is a long withdrawal from their facility and they would have difficulty in coming back. There are therefore many advantages to opting for short-term courses to build the required specialist skills. Even now many mission hospitals and rural private hospitals work with such skills. Even in the government sector we would have many examples of doctors who have done hundreds of cesarean sections and are very adept at it – who have stopped doing it recently due to lack of support.

Also we must recognise that upto the 1970s, this was the norm. Now as specialisations take over – the teaching of these skills to the general doctor in the medical college becomes weaker and weaker. Thus in the 1970s doing surgery like hernias or hydrocele, or assisting in caesarean sections was almost mandatory during MBBS internship and most persons doing surgery were non-specialists. MBBS was considered adequate. Specialisation may have increased quality of care in the urban areas- but it certainly has decreased the quality of care available in rural areas.

Since pre-service medical education has failed to produce the rural doctor that is needed – the commitment to provide health care for all necessarily means that we need a programme of getting the specialist skills in place in rural areas.

It needs to be understood that without a good referral link up to viable secondary care, primary health care providers lose much of their credibility and primary health care loses much of its effectiveness.

The question is therefore not of whether we would have secondary health care available at the one lakh population level. The question is how. And the critical weakness ie. specialists, can be overcome only by substituting the notion of getting specialists in place by getting requisite specialist skills in place.

A list of "common" illnesses most of them life-saving which nowadays only specialists are managing but for which skill-sets can be built up by multi-skilling.

Earaches is a common problem that needs ENT skills.

Corneal ulcers, conjunctivitis, and emergency care are common problems that need ophthalmology skills.

Trauma is a very common problem that requires orthopaedic skills.

Acute abdomens require general surgery- acute appendicitis and perforated peptic ulcers in particular.

Haemorrhoids, hernias, hydroceles are common problems that need surgical skills

Institutional care for the sick neonate and sick child requiring paediatrician skills

Snake bites, scorpion stings, typhoid, cerebral malaria, diabetic emergencies, severe dehydration, hypertension, epilepsy, requiring physician or paediatrician skills

Mental illness – acute psychoses –emergency care, requiring psychiatric skills.

In addition even in much of care requiring super-specialists – regular visits to a primary center or secondary center with occasional consultation at the higher level should be adequate, especially if having a referral link.

MULTISKILLING OF MEDICAL OFFICERS FOR SPECIALIST SKILLS

The Broad Approach:

- Develop norms for what should be the skill mix needed at each CHC (one lakh level) and in th district hospital.
- Get hospital development committees to set themselves clear goals of what package of service they would like to achieve at each level and tailor training inputs to meet this goal. Skill upgradatio would be key to this strategy.
- Assess what are the institutions that are capable - anywhere in India of providing the sort of ski training we seek. These institutions may be public, private or not for profit institutions.
- Developing a basic course structure and quality standards for each of these courses. Though duration would have to be laid down – the emphasis and certification should depend on a measure of what practical, especially surgical training, was given under supervision. Thus not the numbe of months of training but the number of surgeries done independently under-supervision, is the accurate measure of quality of training. And good training evaluation is of course essential.
- The trainees should be posted to a medical college/district hospital/private partner institution and attached to expert clinicians in their specialty for providing hands - on training. During the posting the trainees should be required to observe and practice pre-defined clinical skills and procedures. The trainees are expected to repeat the procedures under observation of the expert clinician who will assess the levels of competence attained by the trainees. The clinical/technical training programmes as identified by training needs assessment (TNA), for each category of personnel, training venue, training duration, number of trainees to be trained, and number of batches to be organised have been identified and presented in following table.
- Develop supportive legal and administrative frameworks- indemnity insurance, transfer and promotion policy issues that can ensure that these skills would be available to the system where it is needed after the training is over.
- Provide for persons to periodically upgrade their skills within their chosen speciality as well. If it is an emergency skill,- since emergencies may be rare, the skill may have to be kept refreshed by doing elective work under supervision at the district hospital periodically.

Given below is a sample of such skills that may be included in a training plan for a two year period This list is an indicative example, not exhaustive and final list.

Skill Category	Specific Skill Training Area/Subject	Duration (Days)	No. of Trainees per Batch
Physician Skills	Management of ICU/ICCU	15	10
	Management of critically ill patients-		
	especially fever with coma and snake bites :	15	5
	Medical emergencies package	15	10
	Non –Communicable Disease package	10	5
	Training in Ultrasound and ECG	15	20
	Training in Echo Cardio and ECG.	15	10
	Essential Drugs and STGs	15	10
General Surgeon	Management of Trauma and head injuries	15	10
	Hemorrhoids, Hydrocele,Hernias	15	15
	Management of critically ill patients	15	10
	Training in Burns	15	15
For general surgeon	Basic Uro-Surgery	15	15
	Basic thoracic surgery	15	15
	Basic Obstetric Surgery	60	5
	Orthopedic Emergencies	15	15
	Training in USG	15	20
	Laproscopic sterilisation	30	10
Obstetrician & Gynecologist	Laproscopic sterilization	30	20
	Emergency Obstetric Care and Obstretical care		
	and Obsterical Procedures for safe Delivery	90	10
	USG/HSG	15	20
	Caesarian Section refresher for Diplomas	30	20
	Only Basic Emergency obstetric care – skilled		
	delvery at birth (esp for PHC doctors)	30	20
	Safe Abortion/MTP	30	20
	Gynaecologic Problem and RTI	30	20
Pediatrician Skills	Newborn Care and Neonatal Emergency (Intensive Care)	30	5

	Care of Premature and LBW	15	10
	Management of severe diarrhoea and ARI	15	10
	Management of Severe Malnutrition	15	10
Anesthetist skills	Training in Basic Anaesthesia for Medical		
	officers for supporting emergency obstetric and		
	other secondary care level surgeries	15	10
	Central Sterilisation and OT management	15	10
Ophthalmology	Foreign body removal	7	10
	Conjunctivitis,Corneal ulcer, glaucoma, iridocylcitis,	7	10
Orthopedic Surgeon	Management of polytrauma cases	15	10
	Common Fractures	30	10
	Accident Emergency	30	10
Radiologist	USG	15	20
	Special Radiological Investigations	15	20
	Management of Imaging Services	15	20
ENT surgeon	Removal of Foreign Bodies	15	5
	Management of common ear problems	15	
Pathology Skills	Blood bank management		
	Basic laboratory management		
Psychiatry Skills	Management of psychiatric emergencies.	30	5
	Management of common neurosis (anxiety and		
	depression) and of hysteria Identification of		
	psychoses and ability to follow up treatment after		
	state level psychiatric consultation and even to		
	initiate treatment where essential		

CURRENT EXPERIENCE

This has been limited to anaesthesia and to emergency obstetric care. (for details of this see Book 2). Most commentators are guarded on this issue, as the experience is still at an early stage. For one there has been a lot of resistance to overcome to get even so much going. The professional associations would have to be negotiated with. The local professional reluctance to open up an area of work within the public sector, that they have managed to get along without doing for so long is another challenge.

Secondly, there was the need to provide consistent support, especially as at the periphery, where there are many other obstacles to overcome. This support needs to come from a change management institution

like the State Health Resource Centre. Another form of support is to keep the skills alive by providing opportunities for elective work to the surgeons at the district hospital– so that when an emergency comes in, the surgeon is confident and fresh with her skills.

Thirdly, quality of skill training is critical. The experience is that the training outcome is not as effective in training institutions where there are also postgraduate degrees or diploma courses- since the post graduates are much more proactive in getting opportunities to perform surgery. On the other hand in centers where there is an undergraduate course only there the opportunities are much more. Even better are the tertiary centers where lot of CS is done but there are no courses at all- but there must be a faculty member available who is very keen on teaching and is well qualified. This is a major scope for cooperation with the private sector as such tertiary care is an area of core competence of the private sector.

“Another form of support is to keep the skills alive by providing opportunities for elective work to the surgeons at the district hospital– so that when an emergency comes in, the surgeon is confident and fresh with her skills.”

Finally, we have to accept a conversion ratio – not everyone trained will be able to start surgery. We should be satisfied if one in two trained start surgery. However not all the training is about surgery and even those who fail to start surgery start managing complications much better. In centres where even institutional delivery was not happening, all this begins.

A general strategy of such skill upgradation has not really been tried – but then in none of the weaker states have they solved the problem of specialists – and the problem is only beginning.

Review Questions

1. Why has skill upgradation of medical officers to provide some specialist services become mandatory?
2. What are the areas in which skill upgradation of medical officers become accepted and programmes are ongoing?
3. What would be the nature of support needed for those who have completed skill upgradation courses?
4. What are the skills in the pediatrics and obstetrics ad gynecomologist domain that need to be provided for a CHC?
5. In a district hospital a basic specialist may require skill upgradation to provide a few super-speciality procedures. Give some examples of this?

Application Questions

1. There is a concern that we are agreeing to settle for lower skill levels for the CHC and district hospital. That we should insist on recruiting specialists. There are two suggestions for this. One is to increase salaries. If needed let them get higher salaries than the IAS. This would solve the problem.. The other suggestion is to make it compulsory for every specialist to serve five years in a rural posting at the discretion of the government. If needed pass laws by which we can conscript them like used to be done by the military and place them in these hospitals? What are your responses to both these alternative approaches?
2. Are there ways of multiplying the availability of specialist courses – at least diploma courses?

Project Assignment Questions

1. Check with IPHS standards for CHC and for the district hospital? Look at the staff position in the district hospital and CHCs in your district ? What are the specialist skills available? What are the areas in which multi-skilling can close the gaps?
2. What are the training institutions in the district and in the state that can potentially be accessed for providing training to close these gaps?

Lesson EIGHT

References, Technical Resources and Further Readings

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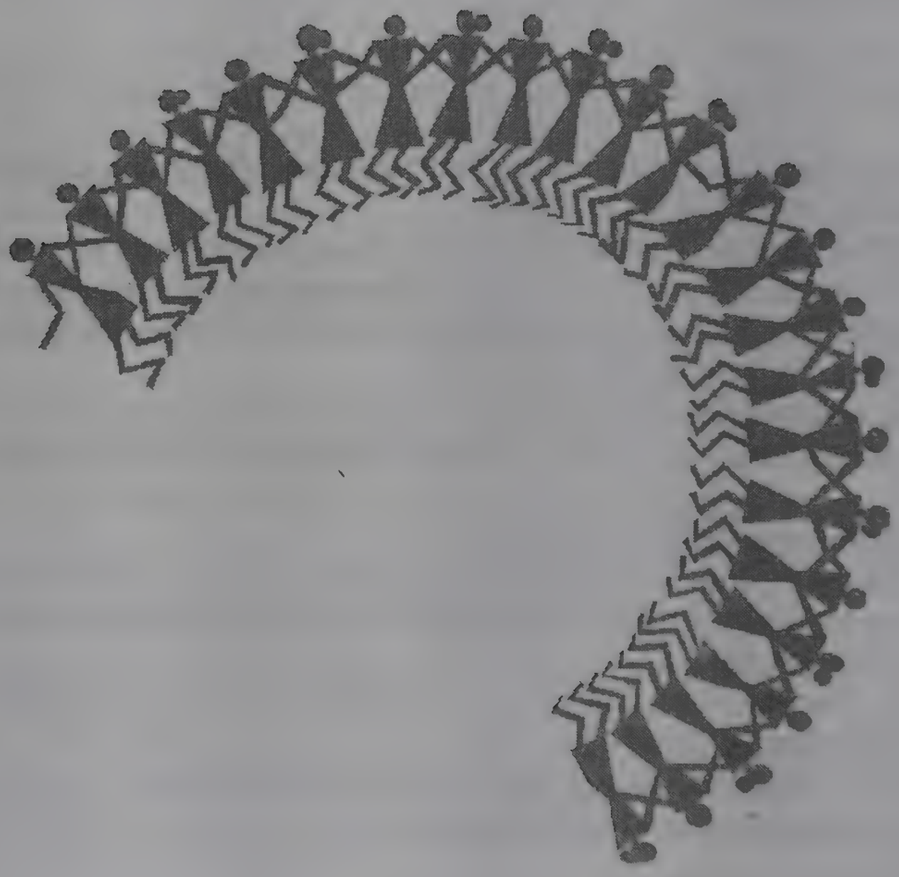

Annexure

Training Policy for Directorate of Health Services, Government of Chhattisgarh

Approved on 11.12.2004

INTRODUCTION AND GOALS

The government of Chhattisgarh adopts this training policy so as to ensure that the public health system has the necessary knowledge and skills for its effective functioning. The goal of such a training policy is to ensure that all the health care facilities – sub health center, PHC, CHC, district hospital, and ISM dispensaries and hospitals, have the requisite skills needed for full capacity utilization and effectiveness.

Training is a very important input in any process to improve the health status and quality of health services. Training is a process of capacity building and of human resource development. All new programmes, and strategies require training of the staff. Even existing programmes need continuous retraining of staff to keep them updated.

Besides training of health personnel, the training structures are also used for training community health workers, advocacy with stakeholders, and capacity building of new players like Panchayati Raj institutions.

This training policy relates only to in-service training. Pre-service training is outside the scope of this document.

OBJECTIVES OF THE TRAINING POLICY

1. Specify the minimum training infrastructure that shall be built up in the state to achieve the training goals.
2. Specify the functions and objectives of each training facility.
3. Specify the training need of each category of staff and how this training need shall be met.
4. Consider the community level capacity building needs and indicate how they shall be addressed.

TRAINING INSTITUTIONS

OBJECTIVES

Sl. No.	Name of Institution	Existing number	Number Proposed	Functions
1.	State Institute Of Health and Family Welfare	0	1(Raipur)	1. Trainlng of Trainers of all para-medicals 2. Training of trainers for multiskilling existing paramedicals. 3. Coordination of Continuing Medical Education 4. Training Materials development 5. Operational Research, 6. Assistance in various health policy development, 7. Administrative training/training follow-up for medical officers and senior paramedicals, 8. Training Evaluation of all training programmes, 9. Guiding and monitoring implementation of the training policy. 10. Supervision of the functioning of the Regional Training Centers and District Training Centers
2.	Regional Training Center (accommo-dation for 60)	1 Bilaspur	3 Jagadalpur, Sarguja	1. Requisite pre-promotion training for female *and* male supervisors. 2. Training, planning and material development on IEC and cultural /communication aspects and locale specific IEC training and programme design 3. Training of trainers for community level workers
3.	District Training Center (accom-modation for 30 to 60)	5	16	1. Training of male and female MPWs and all other class III paramedical support staff. 2. Tele-training reception venue for CME/training for medical officers. 3. Training of ISMs staff for public health goals.
4.	Medical College Training Center	0	2	1. 30 bed capacity hostel with a well equipped meeting/training class rooms; only for the focus on multi-skilling medical officers 2. Upgrading clinical skills of specialist officers; 3. Support to CME programme, 4. Tele-training.

TRAINING NEEDS AND APPROACH FOR PARAMEDICAL STAFF

Needs

- There are about 8,000 multipurpose workers –at the block, sector and sub-center level. They require regular training of at least 18 days once every two years. This is for refreshing their knowledge and upgrading their skills and for multi-skilling them to be able to perform their roles as both a supporting paramedical in the 24 hour PHC and as a MPW in a sub center and in the horizontal integration of the staff.
- There are about 1500 supervisors who need to be trained and multi-skilled to act as effective supervisors and as multi-skilled assistants in the PHC.
- Training and multi-skilling of pharmacists, compounders, unipurpose leprosy workers, dressers etc so that all of them can play an equal role as paramedical support staff in the PHC.

Content of training

1. The syllabus for training paramedical (MPWs included) shall consist of knowledge of all RCH components (this shall include all essential obstetric skills for women para-medicals)
2. Knowledge of National Programmes
3. Ability to do basic laboratory work
4. Ability to dispense medicines
5. First contact care and first aid/dressing skills based on the standard treatment guidelines and drug formulary for paramedical
6. Interpersonal and community mobilisation skills along with better understanding of cultural gaps in a multicultural and ethnically diverse society. This is particularly needed for persons working in tribal areas.

Approach

- Each district training center shall make and maintain a record of each paramedical and support employee and what trainings they have attended. It shall also have a list of the skills available in each facility.
- Every district training center will aim to ensure that over a five year period every facility in its charge has the necessary skills needed at that level and that every employee in the district has the minimum specified skill sets needed as part of that facility- so that the facility is fully functional and optimally used.
- Centrally sponsored training programmes which fit into the above skill set requirement can be reduced from these 18 days. Or else they have to be treated as an additionally over and above these 18 days.

Trainers

The trainers will be of three types:

- One is the full time trainers working in the facility –largely drawn from senior public health nurses or nurse tutors or LHVs who are effective as trainers.
- The second are from the same group who are trained as trainers but called in only for specific sessions – otherwise attending to their main work.
- A third category may be NGO trainers – who must be persons active in NGO work of their own – who are invited for specific sessions where they are effective as trainers.
- **Training of trainers** shall be largely done at the SIHFW.

TRAINING NEEDS AND APPROACH FOR MEDICAL OFFICERS AND SPECIALISTS

Continuing Medical Education

Scheme for medical doctors to upgrade their knowledge and skills shall be initiated. The CME shall be credit based and shall have a core compulsory area and an optional area
Credit points can be gained in one of five ways:

(a) Completing reading of a web-based topic or department CME publication and then sending a feed back form .This could cover core topics like the management of immunisation and the cold chain etc
(b) Attending CME programmes, organised by professional bodies:
(c) Completing a professional periodical based feed back form that is filled in after studying the concerned section or sections - a sort of questionnaire- but there is no pass and fail- only a proof of having read it.
(d) Attending training workshops,
(e) Specific Training in special clinics (private or public sector) for acquiring skills like specific surgery or doing ultrasound etc.

The core area topics and publications shall be specified by the department and must be covered by all. The optional areas are what the individual medical officer chooses to benefit by.

The SIHFW will lay down the credit points for various programmes and shall coordinate various training programmes to be conducted by Department and by Professional bodies.

The SIHFW in collaboration with the training cell in the medical colleges would bring out the CME publications and periodical and would administer the CME programme.

Skill Sets For CHCs: Need for Multi-skilling and Specialisation

Functional CHCs require much higher degrees of skills than are currently available, especially as specialists are not available in most CHCs and even in many district hospitals.

Multi-skilling general Medical Officers for specialist skills in specific priority areas become essential. Multi-skilling has begun with short-term courses in anesthesia and emergency obstetric care- but this would be extended too many more skills till every CHC and district hospital has the minimum skill sets required as per the declared norms.

A related issue is that with some further inputs specialists like general physicians and general surgeons can handle more complex but essential procedures. A general surgeon being trained in laparoscopy is one such example. This training would be a function of the training centers proposed in the two medical colleges. Other tertiary care centers could be accredited for this purpose.

Training for Administration, Management, Accounts and Leadership

All programme officers, district officers and block medical officers need a formal induction in public health management, some aspects of hospital administration and in epidemiology.

The SIHFW/directorate of health services shall enter into an MOU with a health management training institution for a **three month** course of distance education with some contact classes that shall be made available to all medical officers with administrative responsibility.

It will be desirable that all block medical officers and programme officers undertake this course within the next three years.

A more rigorous and through course on public health management of short/long term duration would also be encouraged and for this purpose the state would consider sponsoring candidates to health management institute of national/international repute.

COMMUNITY LEVEL CAPACITY BUILDING

Mitanins

- Another major focus of the health department would be to train trainers for the Mitanin Programme. The Mitanins themselves would be trained near their home villages, but to train 54,000 Mitanins for over a number of years requires about 2700 trainers and these would use the training infrastructure and training manpower available.

- These 2700 trainers would need approximately 15 days of training for the next 5 years per year
- This training would be undertaken by the state health resource center, working in collaboration with the state, regional and district training centers.

Dais

- Training of Dais is yet another major training load.
- This would be coordinated and monitored from the district training centers. Trainers would be trained at the regional centers
- Dai training would be undertaken in institutions (both public and private sector) conducting deliveries over 30 per month and where trainers have been trained. The directorate may enter into MOU with private sector also for this purpose.
- As and when such institutions are identified three persons would be trained and equipped to act as trainers.

Panchayats

Training programme for panchayat leaders and functionaries on health programmes and local health planning is essential. This would be undertaken in cooperation with the department of panchayats.

Private Sector Involvement

- Training is also needed for doctors in the private sector especially in relation to public health programmes and diseases of public health importance. These will be undertaken by district training centers.
- Training for depot holder, self help groups, Anganwadi workers and traditional healers shall be conducted time to time for better convergence.

Training for ISM Staff

- The Directorate of Indian Systems of Medicine has a number of medical officers and para-medicals who would also have a regular in-service training programme.
- The main emphasis of training of ISM staff would be to build knowledge and skills in ISM areas.
- Recognising the lack of synergy between the ISM staff and the staff under the Directorate of Health Service, a number of measures are being introduced to mainstream ISM facilities and staff into public health work. As part of the effort for mainstreaming ISM facilities and staff to help in reaching public health goals, training programmes would be prepared and all the staff would be trained in it.

- Preparation of syllabus would be the responsibility of directorate of ISMs in coordination with the SIHFW and Ayurvedic College. Conduct of training programme would be by the District Training Centers in cooperation with the district ISM officer.

Financing Training Programmes

- Pooling of resources from various national programmes.
- Budgetary training fund allocations from GOI and state Government
- National and international donors/funding agencies.

DIRECTORATE OF TRAINING

- The SIHFW would play the role of supervision and planning for all training functions and of all the training institutions. The heads of all the training institutions in the regional level and district level would be of sufficient seniority and experience
- The director of SIHFW would be of the seniority and pay and rank of joint director and can be/on deputation.
- The director of SIHFW must be a person, not necessarily but preferably a medical doctor, who has played a role in conducting and organizing health training programmes, and in the development of health training materials and who has handled administrative functions. Working experience in public health management, in health advocacy, in IEC work and working with NGOs is advantageous.
- The SIHFW shall preferably be registered as a society so as to enable it to function with adequate flexibility.
- Management of the SIHFW can be outsourced if deemed fit by the Government.

IN CONCLUSION

The objective of the Government in enunciating this policy is to facilitate the blossoming of the potential of each and every employee of the Directorate of Health Services and the Directorate of ISMs and of partners who are working with the directorate to their fullest, so as to enable him/her to contribute their best to the provision of quality health care for all.

Acknowledgements

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Acknowledgements

There are many others who have contributed in various degrees through valuable suggestions and critical comments as well as by providing key reference material. While we are unable to name all of them here due to considerations of space, the editorial coordinators would like to acknowledge their contributions with many thanks!

Public Health Resource Network

A Programme of Sharing Technical Resources to Strengthen District Health Programmes

The PHRN is a civil society initiative to support district level public health practitioners.The core of the programme is a 12-18 month distance learning programme. This course is being organised as a partnership programme of a number of Government and Non-Governmental Organisations and resource centres.

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